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Improving Community Pharmacy Consultations for People with Depression

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Abstract

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Keywords Community Pharmacy / Consultation Skills / Patient Satisfaction / Depression / Medicines Adherence / Consumer Medicines Information / Continuing Professional Development / Medical Simulation.

Aims

The aims of this study were to increase community pharmacists' willingness and confidence to provide consultations for people with depression, and to enhance patients' awareness of the pharmacists' developing role.

Research Design

To observe pharmacist-patient consultations, the researcher developed a patient scenario. Pharmacist knowledge and attitude questionnaires were adapted, and a skills observation checklist was developed. Assessments of patient satisfaction levels took place before and after pharmacist training, which included a simulated consultation and action planning. The consultations were both video recorded and observed. Participants undertook a short interview with the researcher and each pharmacist developed his/her own plan for continuing professional development (CPD). An exploration of the interview transcripts was undertaken qualitatively. A University Ethics Panel approved the project.

Results

There were twenty-two pharmacists who took part in the study, comprising eighteen males and four females. MPharm students comprised one female and

two males, and community pharmacists made up three females and sixteen males.

The quantitative results: It was found that pharmacists possessed appropriate knowledge (the mean score was 75%, which showed that the pharmacists were aware of the safety and action of anti-depressants). The mean score for attitude was 54%, which tends towards the positive. When observing the simulated consultations, the mean score for initiating a consultation session was recorded at 28%. This indicates that the pharmacists were not very interested in initiating rapport with patients. However, the highest mean score calculated was 61%, which corresponded with closing a consultation. For data collection and action, the mean scores were 42% and 35%, respectively, and this indicates the need for improvement in these areas.

The qualitative findings: The pharmacists demonstrated good knowledge about anti-depressants and held positive attitudes towards people with depression. However, the pharmacists were not very willing to exercise the responsibilities of their extended role or provide additional services for patients. The pharmacists lacked certain skills and opportunities to be able to enhance the patients' satisfaction. The pharmacists in this study needed to improve their soft skills in some areas and engage in mutual discussion with patients in order to enhance patients' expectations with the service provided.

Conclusion/discussion

The knowledge and attitude of pharmacists were good, but their consultation skills could be improved. Although simulated consultation allowed pharmacists to review their skills and practice the apparent impact on patient care was limited. This study has enabled greater understanding of pharmacist strategies when consulting people with depression, and the findings could be used by those developing training programmes for enhancing pharmacists skills.

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Abbreviations and Acronyms

ADs	Anti-depressants
FIP	International Pharmaceutical Federation
GP	General Practitioner
HMR	Home Medicine Review
Mind	Mind for Better Mental Health
MMD	Major Depressive Disorder
MUR	Medicine Use Review
NCPIE	The National Council on Patient Information and Education
NICE	The National Institute for Health and Care Excellence
OSCE	Objective Structured Clinical Examination
QSR	Qualitative Research Software
RCP PCYCH	The Royal College of Psychiatrists
RPSGB	The Royal Pharmaceutical Society of Great Britain
SSRI	Selective Serotonin Reuptake Inhibitor
UK	United Kingdom
USA	United State of America
WHO	World Health Organization

Glossary of Terms

Adherence	The extent to which a patient's behaviour coincides with the health-related advice given - in this perspective, the behaviour the patient adheres to may be: taking a medicine, changing their lifestyle, or going on a diet (RCP and RCP PSCH, 2003)
Attitude	An individual's favourable or unfavourable feelings towards performing the behaviour (Fox, 2005).
Communication	The exchange of advice, opinions, and beliefs – representing not only spoken words, but also the things conveyed through inflexion, vocal quality, facial expression, body posture and other behavioural processes (Roter et al., 1998).
Compliance	The extent that patient behaviour follows physicians' recommendations (National Council on Patient Information and Education, 2007).
Concordance	An agreement reached after negotiation between a patient and a health care professional that respects the beliefs and wishes of the patient in determining whether, and how, medicines are taken (National Council on Patient Information and Education, 2007).
Consultation	Consultation is pharmacists-patients discussion about therapy with the intention to assess patient medication related needs. It includes exploring patients concerns and expectation of medications, and involve in shared decision with professional to solve medication related problems (Abdel-Tawab et al., 2011).

Interpersonal	Skills that facilitate the pharmacists' effective communication with the patient (Ramesh, 2004).
Intention	Measuring the probability that an individual will undertake certain behaviours (Fox, 2005).
Self-confidence	When the pharmacist understands his/her ability to manage patients, and monitors diseases, and has the insight to make decisions with certainty about the outcome of the intervention (NICE, 2009).
Therapeutic Alliance	Comprises the active and collaborative contribution between clinicians and patients, together with participation from other health care providers and close family members (Wagner et al., 2001).

The Organisation of the Study

The study comprised six chapters as outlined below:

- The First Chapter: Described the background, introduction to depression and the treatments related and satisfaction of patients to the provision of care, and research strategy.
- The Second Chapter: Provided an overview of the definitions of adherence and related factors, patient related factors, and pharmacist related factors, including the attitude and skills of pharmacists.
- The Third Chapter: Described the aims, methodology and methods used in the research
- The Fourth Chapter: Described the findings (quantitative and qualitative).
- The Fifth Chapter: Included initial interpretation of qualitative findings
- The Sixth Chapter: Discussion (the integration qualitative and quantitative results, implication for the research, future work, strengths and limitations and conclusion).

Chapter 1 Background and Introduction

1.1 The Background to this Investigation

The idea for this investigation arose after the researcher finished his Master's degree in Egypt. The research study for the Master's degree was an evaluation of particular anti-depressants and it focused on clinical efficacy. Dealing with people with depression was a new experience for me, and some difficulties were experienced in collecting data, especially in the early stages of the study. People with depression need professionals to embrace their concerns and understand their expectations, but I needed to focus on data collection, and so it seemed as if our aims were going in different directions. Furthermore, the patients hardly talked to professionals and other people in the community about their concerns and feelings, which made their conditions worse.

One major issue was noticed was that clinicians were busy and lacked the time to talk to patients. Furthermore, many health care providers focused on types of medication rather than on the quality of their relationship with patients, and the patients struggled to find someone who would listen to their concerns. Therefore, patient needs often remained unmet. Moreover, although the role of the pharmacist as a member of the health care team was founded in the educational curriculum, it was absent from real clinical practice in Egypt and in Kuwait. Health care policy and practices empowered physicians over other professionals, so pharmacists did not have sufficient opportunity to interact with patients and, perhaps, did not feel this was their role. The interest was whether this physician/pharmacist relationship was apparent in other healthcare systems outside of my home country of Kuwait.

The first plan for this research was to focus on the impact pharmacists had on adherence to anti-depressants, with a view to comparing the UK to Kuwait. In the UK lots of patient information is available, from the NHS, professional

bodies, charities, and manufacturers of antidepressants, and the pharmacists' concern is helping the patient to read, understand and (as necessary) accept the content of these leaflets. Pharmacists can play a role offering advice and sign-posting of patients, but NICE states that pharmacists should not assume that the patient information leaflets (PILs) meet the needs of each patient (NICE, 2009 A). Pharmacists also need to address the concerns that patients may have after reading the PILs. Addressing patients' beliefs and worries requires the pharmacist to have a good attitude, knowledge and skills (NICE, 2009 A). Many investigations show that pharmacists are reluctant to speak to patients and lack confidence when consulting with people with depression (Rickles et al., 2010). When Aaltonen et al. (2010) conducted a study to compare and contrast the barriers experienced by pharmacy students in different countries when consulting people with depression, students reported that they lacked adequate knowledge about depression. The outcome of the study was in line with a British study (Landers et al., 2002) in which the pharmacists stated they had minimal involvement in identifying the symptoms of depression, or discussing symptoms with patients. Moreover, the participants stated that they had little experience recognising the symptoms and signs of depression.

Thus, the plan was changed to focus on and explore the current and ideal 'consultation' between the pharmacist and the patient, in order to make suggestions to improve the standard of care.

Exploring and understanding optimal health care practice requires a review of NICE guidelines and understanding their recommendations in relation to pharmacy consultations. In addition, the development of consultation practice requires an assessment of the current standard of care and its distance from the ideal situation. It is necessary to help pharmacists reflect on their current practice, and encourage them to make necessary improvements. This study sets out to achieve this.

1.2 Introducing the Study

1.2.1 The Definition of Depression

Depression is a state of low mood that is heterogeneous, varies in complexity and severity, and affects the patient psychologically and physically. The patient with depression may typically feel sadness, irritability and have low self-esteem and suicidal thoughts. Furthermore, they may lack motivation and the ability to derive pleasure from pursuits previously enjoyed. Physical symptoms may manifest themselves as insomnia, parasomnia, changes in appetite and consequent weight gain or loss, a loss of energy and libido, menstrual irregularities, chronic pain, and psychomotor retardation or agitation (WHO, 2012). These symptoms may be prevalent over a period of weeks, months, or years, and may have an impact on family, social and work life. The number and severity of symptoms identify the type of depression experienced. Mild depression accounts for 70% of all cases, moderate depression 20% of cases, and severe depression for 10% of all cases (NICE, 2011). If a patient feels they have depression, then the patient should approach their GP if they experience any the above symptoms for most of the day, every day, and for more than two weeks. In the UK, depression is classified on the following scale: mild depression - has some impact on daily life; moderate depression - has a significant impact on daily life; and severe depression - makes it almost impossible to get through daily life (NICE, 2012 A).

1.2.2 The Prevalence and Incidence of Depression

Depression is a mental disorder that is prevalent throughout the world. Globally, it is estimated that depression affects 350 million people of all ages (Marcus, 2012) and is considered the second leading cause of loss relating to 'disability adjusted life years'. It is a major contributor to the Global Burden of Disease

(GBD) (Ferrari et al., 2013). The GBD is the cumulative disease burden produced by all diseases around the world and GBD statistics use the term 'disability adjusted life years' (DALY) to facilitate comparisons to calculate an estimate of life years lost and life years lived due to specific diseases, incorporating other epidemiological data. An analysis of the 2010 study indicates that one of the leading causes of 'years lived with disability' (YLD) is major depressive disorder, which appears in the top ten diseases for all countries (Vos et al., 2013). Between 1990 and 2010, there was a reported increase of 37% in DALYs (Murray et al., 2013).

Depression has a high prevalence worldwide. It affects 400 million people of different ages throughout the world. The prevalence of mild depression and anxiety in the United Kingdom is approximately one in every five adults (British Psychological Society, 2013). In the UK, incidence rates of depression occur in 3% to 6% of the adult population (NICE, 2011). It is hypothesised by McCrone et al. (2008) that by 2026 the number of British people diagnosed and requiring treatment for depression will rise to 17% of the population (to 1.45 million) and that service costs to treat depression will rise from £1.68 billion to £2.98 billion. However, these values do not indicate an actual rise in the rates of depression, but are relative according to rising population numbers. In 2007, depression accounted for nearly £6 billion of lost earnings. Furthermore, limitations to McCrone et al.'s analysis include the fact that only primary diagnoses of depression are considered, and certain patient groups are not included in this study, including those with learning disabilities, those receiving informal care, and those in the criminal justice system. It is impossible to ignore the absence of this missing data because it reduces the projected impact of depression on the general population, service usage, the cost of services, and the economy as a whole. NICE clinical guidelines (2009 B) state that, "depression is two to three times more common in people with a chronic physical health problem." This suggests that the 20% of the population who suffer from conditions such as cancer, heart disease, and diabetes, musculoskeletal, respiratory, or neurological problems may also suffer from depression.

1.2.3 The Causes of Depression

As indicated in numerous families, twins, and adoption studies, genetic factors play an important role in the development of MDD. Studies on twins suggest a heritability of 40% to 50%, and family studies indicate a twofold to threefold increase in the lifetime risk of developing MDD among first-degree relatives (Lohoff, 2010). Additionally, biological factors can contribute to depression. Communication between neurons takes place via special sites of contact known as synapse, which are located in the nerve endings. Messages transmit between neurons using amnion acid via neurotransmitters such as serotonin, dopamine and noradrenaline. When the mood regulating neurotransmitters fail to function in a normal way, the signals deplete or disrupt before they transmit to the next nerve cell (Royal College of Psychiatrists, 2012).

Life events and significant life changes can often be a precipitative factor of depression. Bereavement, divorce, illness, employment problems including loss of employment, financial problems, or stress following trauma may all trigger an episode of depression. Additionally, adverse psychosocial factors resulting from deficient parent nurture, emotional and physical abuse, neglect and parental separation may induce childhood or retarded adult depression (Moy, 2009). Certain psychological factors can also put people at risk of depression, for example, people with low self-esteem who consistently view themselves and the world with pessimism, or those who easily overwhelmed by stress may be prone to depression (Grohol, 2015).

1.2.4 Prognoses

The opportunity to develop depression in children is considered unusual. An estimated 0.2-2 % of children develops depression before puberty and it is equally among boys and girls. However, after puberty, the tendency to develop

depression among girls is three to four times with boys and 3-4% of teenagers suffer from depression (Wasserman, 2011). The average recurrence rate of depression is twice in a patient's life. Individuals with a history of three previous episodes of depression are 90% more likely to have fourth, and due to this high relapse rate, guidelines recommend that individuals with a history of multiple depressive episodes receive medication for the rest of their lives (American Medical Association, 2012). A cohort study conducted in Netherlands finds a high number of pain locations associated with depression, such as pain of the joints, and longer periods of duration of pain (for 90 days or more) among people with depression. The daily use of pain medication and experiences of more severe pain at baseline levels are associated with a significantly increased risk of having a depressive or anxiety disorder (Gerrits et al., 2012). A survey conducted on older people in Canada who had history of depression finds that people with major depression who were smokers or had low levels of mastery were at an increased risk of repeated episodes of depression (Colman et al., 2011). A study by Clancy et al. (2013) uses semi-structured interviews to explore the experiences of smokers with self-reported depression in Australia. In this study, low moods, anxiety and stress are triggers for smoking, and many participants described a close relationship between their mood and their smoking behaviour. However, one of the limitations of this study is that interviews took place over the telephone.

1.2.5 Risk Factors Relating to Depression

Depression is a risk factor in the development of a range of physical illnesses, such as cardiovascular disease, for example. When a person has both depression and a chronic physical health problem, functional impairment is likely to be greater than if a person just has depression or a physical health problem alone (NICE 2009 B).

A cohort study conducted in the USA that focuses on psychosocial factors and health outcomes among patients with stable coronary heart disease finds that patients with depression are associated with an increased risk for cardiovascular disease. Tests for both somatic and cognitive symptoms were undertaken using a patient health questionnaire. However, the participants in this study were mainly older men and, therefore, the results may not be generalisable to women or to other patient populations (Hoen et al., 2010).

Another cohort study carried out by Linke et al (2009) examines patients with myocardial ischemia who have undergone evaluation at baseline for a history of cardiovascular-related problems. Tests on their depressive symptoms were undertaken using the Beck Depression Inventory and the results indicated that somatic but not cognitive symptoms of depression significantly predicted cardiovascular events. However, the participants in this study were all women. Win et al. (2011) tested the risk of cardiovascular mortality due to physical inactivity and depression in the USA, the study showed that community-dwelling older adults with high depression scores were at an increased risk of cardiovascular mortality. In this study, individuals with symptoms of depression are at 67% greater risk of cardiovascular mortality than individuals who scored low depression. One drawback of this study, however, is that it focuses only on elderly patients. Furthermore, Pan et al. (2011) find that diabetes and depression are significant risk factors for all-causes of CVD mortality, whereas the coexistence of these conditions is associated with a much higher risk. The authors also observed a strong monotonic relation between diabetes severity and CVD mortality rates. However, the information regarding diagnosed diabetes and depression used in this study is undertaken using self-reporting.

1.2.6 The Management of Depression

Cleare et al. (2015) describes how we can manage depression according to the severity of symptoms as follows: For symptoms on the mild to moderate scale,

e.g. for mild major depression (few symptoms beyond the minimum and mild functional impairment) and moderate major depression (more than minimum number of symptoms and moderate functional impairment), cognitive behaviour therapy (CBT) - behavioural activation and interpersonal psychotherapy (IPT) are recommended as alternatives to anti-depressants. CBT for acute treatment is necessary with psychological treatment as a mono-therapy for recurrent depression.

For people with mild to moderate depression who have not benefited from low-intensity psychosocial intervention, practitioners are recommended to discuss different treatments with patients and provide anti-depressant first line medications such as selective serotonin reuptake inhibitors (SSRI) (NICE, 2009 A) see (Appendix-1). Treatments take place within primary care and should include education about depression, an examination of lifestyle, and suggestions for lifestyle changes. Aspects of lifestyle advice might include teaching problem-solving techniques, considering relationships with significant others, offering specific assistance as required, and providing supportive monitoring. There is no evidence for the necessary use of pharmacological or psychological treatments in this group unless the symptoms persist beyond eight weeks, then non-medical treatments with cognitive interpersonal psychotherapy (IPT), behaviour therapy (CBT), or a selective serotonin reuptake inhibitor (SSRI), in addition to supportive management may assist (Ellis et al., 2003).

For people starting to take anti-depressants, practitioners may consider suicide risk and toxicity in overdose, and explain that symptoms of anxiety may initially worsen. Practitioners must explain that anti-depressants take time to work and that anti-depressants work best when they continue for at least 6 months following the remission of symptoms, because sticking to this timeframe greatly reduces the risk of relapse (NICE, 2015 B). Practitioners can also refer patients

to self-help groups and it is wise to consider this course of treatment too. A link with an organisation or well established group can offer the necessary resources and support, and patients can interact in a non-stigmatising and welcoming venue to engage in recovery focused treatment in an a confidential atmosphere (Scottish Intercollegiate Guidelines Network, 2010).

1.2.7 Patients Seeking Help

In order to satisfy the information needs of patients, particularly those who need access to coping strategies it is useful to guide people with depression to a variety of resources. Many people with depression will need more information and support than general practitioners are able to provide due to the limitations of GPs' skills and time (Barney, et al., 2011).

A study by Khazaal et al. (2008) of elderly outpatients who had psychiatric diseases in Switzerland finds that two thirds of patients who used the internet to access information were partially satisfied with the information they found. Reasons for using the internet included finding out information about medications, and finding out general information about health issues. One of the drawbacks of this study, however, was that the participants had a professional education and this meant they had privileged access to and understanding of the internet.

A study by Byers et al. (2012) of older dwelling patients with a 12-month+ anxiety or mood disorder found that the great majority did not use mental health services. The incidence of non-use was high across all income groups and low perceived need groups, and not using services was associated with patients with mild mood or anxiety disorders but no chronic pain or minor cognitive complaints. These findings suggest that low perceived needs, moderate resources, and low motivation to use mental health care services explains why

patients do not seek services, despite patients having diagnosable mood and anxiety disorders. Furthermore, in a study by Tanskanen et al. (2011) patients describe remaining unaware of their psychosis until they had contact with mental health services. This study used semi-structured interviews with patients who had initiated meetings with doctors in the UK and who were subsequently prescribed anti-psychotic medications. The patients describe how difficult it was to seek help because doing so was often complicated, prolonged, and involved various attempts of intervention by family, friends and community organisations. In some cases, patients sought help without the service users' knowledge and/or consent. However, the mean age of participants in this study was 26 years.

A study undertaken in Australia by Schrank, et al. (2010) uses semi-structured interviews with schizophrenia patients to assess whether the internet is a good place to search for information about this illness. Most patients said the internet offered them anonymity and shielded them from the effects of social hierarchies. They also said that the internet helped them to overcome issues relating to stigma when interacting with health care professionals and others. However, in a cross sectional study by Borzekowski et al. (2009) of patients in the USA who had serious mental illnesses, one third reported using the internet, but those who used the internet said their usage was infrequent. One drawback of this study, however, is that over a third of the participants had not reached high school level education, and this might account for their approach to internet usage when seeking information about illnesses.

In semi-structured interviews undertaken by Anderson et al. (2013) with patients who had experienced first episode psychosis in Canada, twelve participants made comments relating to the stigma surrounding mental illness and said they experienced this when seeking help for their psychotic symptoms. Although none of the patients described a situation in which they were directly stigmatized, many used words and descriptions that indicated they had internalised society's stigma against people with mental illnesses. However, the

patients in this study covered those with effective (psychotic) and non-effective (depression) who may hold different beliefs about stigma. Similarly, a study by Yap, et al., (2013) of Australian young people identifies family, friends and relatives as people to rely on for support if mental health becomes a problem. Embarrassment and concerns about stigma and outcomes after having consulted a health care professional rated highly as barriers to seeking help. However, this study relies on a vignette approach and so the respondents might have actually decided to do something different when genuinely faced with mental health problems.

A focus group conducted by Uebelacker, et al. (2012) with Spanish patients who had depression finds that barriers to receiving care for depression include stigma from the community, attitudes toward depression that include ignoring or expecting depression to disappear, and expecting people to tackle depression themselves. One drawback of this study, however, is that its participant sample was Latino patients. To investigate how cross national differences relating to attitudes and stigma impact on seeking professional and informal help, Reynders et al. (2014) devised a questionnaire targeting the population of Netherlands and Flanders. They find that people from the Dutch are more inclined to seek help from general practitioners and psychiatrists if they had experienced mental health issues. In comparison to Flemish people, people from the Netherlands showed positive attitudes towards seeking help, but Flemish people were more sensitive to self-stigma and feelings of shame surrounding mental illness. The authors suggest that organisational factors (the accessibility and availability of mental illness) play an important role in peoples' decisions to seek help from health care professionals. However, the results were calculated using a self-reporting method and did not actually assess mental health symptoms.

When Bristow et al. (2011) organised semi-structured interviews with people who had mental disorders, the authors found that patients were reticent to seek help generally, not only relating to consulting their GP, but because they feared issues of stigma generally because they had a mental health issue. However,

this study was limited to homeless peoples and minority groups. Holm et al. (2014) report that patients with depression sometimes think that health care providers do not believe them when they say they have physical health problems, and just assume that patients are imagining these symptoms because they have depression. Patients in the UK said that this kind of discrimination adds levels of shame and worry relating to their illness. However, one drawback of this study is that it focuses only on community health care centres.

1.2.8 Satisfaction with Anti-depressants

Addressing non-adherence is not about getting patients to take more medicines per se, rather it is about starting with an exploration of patient perspectives of medicines and the reasons why they may not want to take them or are unable to use them. Healthcare professionals have a duty to help patients make informed decisions about treatment and use appropriately prescribed medicines to their best effect (NICE, 2009 C).

Patients who were surveyed in the Kingdom of Saudi Arabia indicated they were highly satisfied with the anti-depressants they received (Aljumah et al., 2014). Among the patients who recorded satisfaction were those who reported experiencing side effects after using anti-depressants. However, the study did not find any evidence of a correlation between beliefs about medicines and the relationship of the patient with their health care providers. The author suggested that possibly, the relationship patients had with their pharmacists and GPs might have affected the results towards positive conclusions. In a study by Tranulis et al. (2011), 60% of patients prescribed with psychotic drugs took their medicines without engaging in a mutual discussion with a health care professional. Semi-structured interviews revealed that patients were often passive and took medications based on trust in what their health care providers told them. However, patients who took part in this study only belonged to one

clinical setting. Dolovich et al. (2008) finds that Canadian patients think their relationship with their physician is important in relation to adherence and if they want to discuss issues about their medications. Some patients in the study felt disconnected from their physicians and said that physicians do not listen to them and do not communicate well with them. However, this study does not focus exclusively on mental illness but surveys those with physical disease also.

Similarly, with patients interviewed in the USA by Anderson and Roy (2013) physicians were sometimes dismissive, did not pay enough attention to patients, and did not foster good relationships with patients. The authors claim that the relationship with their health care provider influences a patient's adherence to their medications, but this study does not survey physicians, only patients. The findings suggest that concordance, or shared decision making with regards to medicine taking, is only occurring to a limited extent; in only a quarter of consultations were patients given treatment options or provided a rationale for a proposed medication/treatment. In only a fifth of consultations did the prescriber (pharmacists, general practitioners and nurse) elicit the patient's preference for treatment and in a quarter did the patient express a treatment preference. This is despite the suggestive evidence found in this study that spending longer discussing treatment options was associated with greater patient satisfaction, adherence. However, a randomised controlled study conducted with a 6-month follow-up. Participants were randomly allocated to two groups: 1) intervention group (IG) and control group (CG) to people with major depressive disorder. After 6 months, IG patients showed statistically significant increases of up to 18 % in adherence to antidepressants and 6 % in treatment satisfaction, and a decrease of 8 % in concern beliefs and general beliefs about medicines (Aljumah and Hassali, 2015).

1.3 The Search Strategy

Researchers can use many different databases. In the current study the researcher focused on using four databases: 'Web of Science', PsycINFO, Medline, and the Cochrane Library. (Appendix-3) outlines the full research strategy. Web of Science, PsycINFO and Medline are databases covering medical, scientific and psychological publications, while the Cochrane Library contains a systematic review of meta-analyses. The search terms used in these four databases include both free terms and MeSH terms. The free terms include truncation while the Subject Librarian suggested MeSH terms without truncation. The results of the database searches was in 2012, where 153 articles and 2 systematic reviews were found. Of these 153 articles, 23 were included because they are relevant to the current research. All studies published in the databases were included except personal experience and non-English language articles. Furthermore, theses and books were included. Relevant randomised controlled studies for the current research offer similarity to the circumstances of United Kingdom culture, (e.g. Europe) even though studies conducted in Middle Eastern countries compare with the United Kingdom.

Chapter 2 Literature Review

This chapter explores the work undertaken by previous researchers about medicine adherence and/or compliance among patients who visit pharmacies. Adherence encompasses a range of patient behaviours relating to the collection and taking of medications according to recommendations made by health care professionals. Matters relating to adherence also encompass individual and autonomous patient views about taking medications. Scientists divide non-adherence into two types: unintentional non-adherence, such as forgetting to take medications; and intentional non-adherence, which may be triggered by experiences of stigma or other beliefs a patient holds about certain medications. One of the roles of the pharmacist is to encourage adherence to medications in collaboration with other health care professionals. Patients benefit when providers liaise with other health care professionals to co-ordinate adherence and a health care plan. However, many obstacles exist that act as a barrier to the effective collaboration between pharmacists and other healthcare professionals, and, sometimes, pharmacists find these obstacles challenging to overcome.

This chapter also explores the role of the pharmacist, the work of the pharmacy, and the attitudes of pharmacists towards mental illness in comparison to physical illness. The chapter describes the extended role of the pharmacist (as outlined and recommended in international guidelines) for building relationships with patients and exploring medications from the perspective of the patient's agenda. Furthermore, the chapter explores the knowledge pharmacists must show about anti-depressants and how the pharmacist must work to try to satisfy patient needs. When trying to place the patient at the centre of care, pharmacists encounter challenges. This subject is debated in previous research and in studies into the ability of the pharmacist to engage with people with depression.

2.1 An Overview of Adherence

Adherence to anti-depressant medication is low in people with depression. Previous research explains and explores possible reasons for poor adherence. Interian et al. (2007) find that poor patient adherence to anti-depressant medication is attributed to patient beliefs about use of medication being an admission of their inability to successfully cope with their mental state. Barney and Griffiths (2011) state that patients are concerned about the stigma attached to taking anti-depressants, and they think it is a personal weakness having to resort to such medication.

Patients are concerned about how others might respond to their diagnosis of depression. Houle et al. (2013) reports that the treatment preferences of patients suffering from depression can affect adherence and clinical outcomes. Their research finds that of those patients suffering with depression the majority favour psychotherapy (41%) over taking an anti-depressant (31%). NICE guidance states that non-adhering patients are not deviant because limitations within the delivery of health care may be the reason for non-adherence. Failure to involve patients in the decision to commence medication and a lack of on-going support are some of the reasons cited for non-adherence. Exploring the patient's ideas, beliefs and perspectives on anti-depressants may form the basis of discussion to improve adherence (NICE 2009 C). The following section will discuss the different behaviours involved in adherence.

2.1.1 The Behavioural View of Adherence

In order to maximise the effectiveness of medicines in several acute diseases it is particularly important that patient take their medicine according to the proven dosage regimen. Fundamentally, Buxton (2011) states that compliance can be defined (to a particular regimen) as the level to which individuals take their treatment as prescribed. Another description of adherence relates to the behaviour the patient adheres to which might be taking a medicine, changing

lifestyle, or going on a diet (Pignone and Salazar, 2013). To make sure that specific treatments work effectively it is important to take drugs on time, every time (Cauldbeck et al., 2009). Adherence is the capability of the individual to visit the clinic as scheduled, take the medication as instructed, change their way of life, and follow the recommended investigations (RCP and RCP PSCH, 2003). A further definition of adherence focuses on the extent to which the patients' behaviour matches agreed recommendations for the prescriber (Julius et al., 2009). The term 'adherence' can be used as a synonym to (compliance) which indicates matching to the recommendations made by physicians, including dosage, timing and the frequency of anti-depressants taking (Cramer, et al., 2008 B). This context assumes increased patient involvement in choosing the regimen; in other words, the patient agrees to take the medicine, however they may not take it precisely as prescribed.

Therefore, behaviourally, adherence comprises two components: the level or frequency of the treatment used during the period of therapy, and the persistence in taking the medication during the whole period. WHO (2003) states that adherence is not only based on the patient's agreement with health advice about the risk itself, but other important influences on adherence are: the clinician's skill and capability to convey to the patient that the medication is useful; and the patient's observation of the clinician's trustworthiness, sympathy, enthusiasm and concern.

It is apparent from previous research, that the definitions of adherence (so far considered) do not include impact on clinical outcomes. Agreement with health care instructions can be nil, irregular, over-used or under-used. However, complete adherence is only justifiable if the prescribed dose is essential to provide full benefit, particularly if there are considerable side effects. The next section will consider the relationship between adherence and outcomes.

2.1.2 The Individual View

Fisher (1992) views non-adherence as an assessment of the patient to achieve a therapeutic objective. Haynes et al. (1979) define adherence as the level to which patient behaviour agrees with instructions from health care providers. The emphasis is that of 'blaming the victim' when patients do not comply with the physicians' orders and on the paternalistic role of the physician and the subservience of the patient (Cipolle, et al., 2012). Mullen et al. (1997) are critical of the theory that high adherence is synonymous with a willingness to obey doctor's orders, believing that this shows disrespect for human autonomy. Agreement with the provider has been also criticised (NCPIE, 2007) as an excessively arbitrary approach which stigmatises the application of independent judgement by patients as 'deviant behaviour'. Focusing on 'fulfilment' of the doctor's intentions indicates the physician is exerting authority effort with a patient to make them "surrender" to their therapeutic directives. The issues surrounding the debate on adherence improvement is highlighted by Mitchell (2007) who justifies that poor patient engagement in the therapeutic regimen might be a consequence of one or more factors, including improper understanding of the regimen, the value of medical advice, or a lack of self-management. Alongside patient's involvement in a decision to adhere with a regimen, the professional's involvement levels are important. This is one of the earliest papers to suggest the importance of a non-judgmental approach to adherence. Simply, the degree of adherence to treatment is not something that is open to judgement or anticipation beforehand, rather the professional should try to convince the patient to adhere to treatment and then the patient should decide (Dunbar et al., 1979).

This section focuses on definitions of 'adherence' that are relatively old simply because the term has not developed further, and many new studies refer to the same definitions. In our research, The term 'adherence' will be used in the context of patients bringing in a prescription to the pharmacists with aim of taking medications that fit to their lifestyles and health conditions. The patients

used in our research had mild to moderate depression and were capable of making decisions about their medications. Moreover, one of the responsibilities of the pharmacist is to check that a patient agrees to their medications, especially because adherence to anti-depressants is influenced by many factors that will be discussed in the next section.

2.2 Types of Adherence

Adherence measures the extent to which patient behaviour follows agreed and prescribed treatment plans in terms of dosage and frequency. Non-adherence is one of the main reasons for the failure of clinical objectives and sub-optimal medical outcomes (Cramer et al., 2008 A). The main obstacle faced when promoting adherence is that patients hold different attitudes about their treatments, and these attitudes can turn into behaviours affecting their adherence to treatments. Therefore, investigators usually divide non-adherence related behaviour into two groups: intentional behaviour and unintentional behaviour.

2.2.1 Unintentional Non-adherence

There is no clear definition of unintentional non-adherence. It ranges from incomplete to total non-use. Rau (2005) presumes that this behaviour is the consequence of a passive process not significantly associated with conscious beliefs. However, the failure to understand treatment regimens due to language problems has been identified as a significant cause of unintentional non-adherence (Rau, 2005), but, unintentional discontinuation of treatment is also caused by other factors apart from language problems. Sahm et al. (2009) claim that the number of patients who discontinue their anti-depressants unintentionally ranges from between 20% and 50%, and many investigators find that incidents of discontinuation can relate to access to medicine, patient schedules, and patient memory. When Clifford et al. (2008) performed a cross-

sectional survey in the UK, of patients starting new medications for a chronic conditions they explored beliefs about medicines using the Necessity–Concerns Framework. They assessed self-reported adherence using telephone interviews. The similarities found between adherers and unintentional non-adherers suggest that beliefs about specific medicines are not associated with unintentional non-adherence when patients start a new medicine for a chronic condition. Clifford et al. (2008) argue that unintentional non-adherence might be associated with forgetfulness, but they did not demonstrate this in their study. However, the patients were elderly and had chronic diseases.

Other research proposes that there is likely to be more unintentional non-adherence rather than pure forgetfulness or carelessness (people who have a low perceived necessity for their medication may see it as more likely to forget to take it). A study conducted on Japanese patients illustrates this theory (Iihara et al., 2008). In 2009, Miaso et al. published a cross sectional, descriptive, qualitative and quantitative study exploring the opinions of patients with Bipolar Affective Disorder. The study finds that just over half the participants were forgetful and careless regarding taking their medications, but the majority of the patients were satisfied with their health care service. However, many of the participants who took part in this study were elderly and might have had cognitive behavioural reasons to account for why they could not adhere to medications. Another cross-sectional study by Awwad et al. (2015) evaluates patient knowledge of and adherence to medications as a score out of seven. This study finds that patients are modestly knowledgeable about adherence regimes, with about 60% scoring equal to or greater than four. Youth, higher education levels, taking fewer medications, and having fewer diseases were significant predictors of possessing a greater knowledge of medications.

In a cross sectional study of non-adherence by Gadkari and Mchorney (2012) undertaken in the USA using patients over the age of forty years, 70% of patients self-reported three instances of unintentional non-adherence behaviour

during the previous six months, with 62% of patients stating that they did not take their medications due to forgetfulness. This study shows a strong correlation between age and unintentional non-adherence: the older the patient, then the lower the chance of unintentional non-adherence became (Gadkari and Mchorney 2012). Likewise, in a study by Tang et al. (2013), Chinese patients taking antiepileptic medicines reported forgetfulness as the main reason for unintentional non-adherence to their antiepileptic drugs. However, the finding showed that patients discontinue their medications when experienced seizure-free for a period (48.9%). This argument may indicate that patient were not accurately educated about the benefit of persistence to their medications, but the weakness of this study is that it targets one hospital only. Furthermore, Da Silva Barreto et al. (2015) find a high correlation between non-adherence and dissatisfaction with health care services, physicians, and other health care professionals, but the majority of the patients studied in this research were elderly.

Therefore, previous research reveals no single specific main factor that leads to unintentional non-adherence, and a variety of different cognitive and non-cognitive factors can lead to unintentional non-adherence.

2.2.2 Intentional Non-adherence

For some patients, taking treatment regularly might not be appropriate for their lifestyle, or for the conditions in which they work. Patients cite several reasons why they intentionally do not take medications including: workloads, concerns about the side effects of treatment, and fear of dependence. Additionally, some patients exhibit a mixture of intentional and unintentional behaviours, as noted by Eliasson et al. (2011). A study by McHorney (2009) suggests that intentional non-adherence has a variety of causes, including the symptoms or severity of the disease, regime complexity, experiences of medication, prescription error, and patient beliefs about their medication. However, the mean age of

participants in McHorney's study is fifty-nine years. When Wouters et al. (2014) studied non-adherence to anti-depressants in primary care, the results showed that worries about or previous experience of side effects were more likely to be associated with non-adherence behaviour, but in this study the authors do not mention the severity of depression experienced by patients.

Van Geffen et al. (2007) claim that patients can experience early side effects from taking anti-depressants before they perceive the efficacy of their drugs, and this can lead to non-adherence. However, intentional non-adherence can occur not only due to the failure to collect a repeat prescription or the cessation of previous treatment, but by ignoring the advice of the health care provider or changing dosage without informing the care provider. According to Osterberg and Blaschke (2005), nearly 15% of patients do not collect repeat prescriptions and 50% of these patients cease taking their medication within the first six months of treatment. Osterberg and Blaschke find that patients are more likely to stop taking their medications if the medications do not match the patient's needs.

Therefore, in summary, although different factors are associated with intentional non-adherence in depression, the main cause listed for intentional non-adherence is the fear of or experience of side effects. The next section will explore patient related factors that have an impact on adherence to treatments.

2.3 Patient Related Factors

Many different factors can make a patient decide not to adhere to their course of treatment. Beliefs about stigmatisation and the personal attitudes of patients and pharmacy staff can have an impact on whether or not someone might adhere or not adhere to their medicines. The next section will discuss these factors.

2.3.1 Stigma Attached to Patients

People with depression sometimes perceive stigma and this has a negative effect on their attitude and reactions towards treatment. Research by SANE (2014 A) finds that 55% of patients with depression in Australia feel that it is difficult for them to inform their employers if they need to take leave due to depression, and this percentage is even higher (72%) in Europe. In a report by SANE Media Centre (2011), 75% of four hundred twenty seven people with mental illness surveyed said they experienced public stigma or discrimination in 2011, and these results are consistent with research carried out in 2006. Furthermore, SANE (2014 B) suggest that experience of this kind of prejudice has not declined over time. Indeed, Mental Health Care (2014) note that the number of patients who experience stigmatisation associated with mental health is high, and mental health patients think that the public holds stereotypical views about mental health. For example, in a survey conducted in the UK in 2012, 88% of patients believed that the general public associate schizophrenia with violence.

People with depression often feel uneasy when informing other people about their illness, and they report experiencing the same feelings when meeting with caregivers. An Australian study by Knox et al. (2013) explores the perceptions and experiences of people with depression and their caregivers. It finds that patients often experience stigmatisation from staff in the pharmacy as well as from other patients in the pharmacy. However, it is worth noting that the authors do not explicitly use the term 'pharmacist' when referring to staff in the pharmacy, and, therefore, this research might refer to the different kinds of staff who work at a pharmacy not just pharmacists. Nevertheless, this is a worrying finding.

In a survey of pharmacy students in Estonia, 86.4% believed that people with schizophrenia are unpredictable, and 47.5% believed that people with schizophrenia are dangerous (Volmer et al., 2008). Furthermore, 25% of the

students agreed or strongly agreed that negative attitudes can affect the consultation skills of pharmacists when they deal with people with depression. The authors suggest that some students are unaware that their attitude may limit their service. The study uses undergraduate students as participants, but the authors do not mention the stage at which students are at, or whether this has any bearing on how they perceive people with mental illness.

In a study by Abo El Magd and Zamil (2013) which compares the attitudes of medical students (pharmacists and nurses) with the attitudes of non-medical students towards people with mental illness, nearly a quarter of the participants held negative attitudes about people with mental illness. The stereotypes held by the participants included the belief that those with mental health problems are dangerous and aggressive. However, the medical students showed more positive attitudes towards people with mental illness than did non-medical students. The authors suggest that medical students are more knowledgeable and have more awareness about mental illness and this means they engage in less stereotyping.

Pollock and Grime (2002) find that pharmacists who are knowledgeable and have the skills to communicate effectively with people with depression are more able to reduce the stigma associated with depression. This study finds that developing knowledge about depression and treatments for depression can help to open up discussions with patients, and this helps patients to feel less stigmatised. The authors find that pharmacists are aware of the stigma attached to depression and mental illness, and that pharmacists know some patients are embarrassed when they visit pharmacies. In a study by Guillaumie et al. (2015), a focus group of pharmacists showed the willingness and the knowledge to help patients and to reduce stigma. The pharmacists studied were able to provide information about anti-depressants and treatments, they emphasised the benefits of anti-depressants, and they reduced the fear of side effects. Notably, however, the majority of the pharmacists in this study had experience in their job of more than fifteen years, and this might account for their more positive

attitudes towards depression. Furthermore, a study by Gable et al. (2011) undertaken in the USA, which explores perspectives about mental health held by pharmacy students, uses a control group and an intervention group. Students from the intervention group who were required undertake training about mental illness showed positive attitudes towards mental health in comparison with those students in the control group. However, the sample size used in this study was small.

The difficulty experienced by pharmacists when they try to engage with patients is one issue that contributes towards patient perceptions of stigmatisation. In a study by Liekens et al. (2013), pharmacists disclosed that they feel social distance from patients with depression who visit the pharmacy even though they deal with many such patients on a daily basis. The authors find that the quality of communication between the pharmacist and the patient helps to remove stigma more than the amount of patients with depression who visit the pharmacy. A consumer-led mental health education study by O'Reilly et al. (2010 A) conducted in Australia finds that patients who engage more with pharmacists are more likely to experience reduced levels of stigma. The students said that when patients talk to them they could see that they often lead normal lives in spite of having depression. This study shows that patient engagement with students helps to eliminate prejudices surrounding the issue.

In a study by Buhler and Karimi (2008), pharmacy students held negative attitudes about patients with depression, and some believed that patients with depression lacked willpower or lived immoral lifestyles. However, after the pharmacy students attended peer-level patient presentations and an educational course on depression, more of them were comfortable with the idea that patients with depression would benefit from taking anti-depressants. The authors suggest that undertaking peer-level patient presentations and a training course is effective to overcome perceptions of social distance experienced between pharmacists and people with depression.

To summarise this section, patients with depression often perceive feelings of stigmatisation, and pharmacy staff sometimes hold negative attitudes and prejudices about patients who have depression. Pharmacists are less willing to help reduce levels of stigma when they lack proper training. The evidence suggests that students who receive training about how to engage with people with depression become more aware of the stigma surrounding the illness and then make efforts to overcome it.

2.3.2 Beliefs of Patients about Anti-depressants

NICE (2009 C) explain that intentional non-adherence occurs when patients decide not to take their medications or not to follow therapeutic instructions. The patient's understanding of their illness and their concerns about taking anti-depressants influences these decisions. It is interesting to note that in a study by Houle et al. (2013) to assess the beliefs of Canadian patients recently prescribed with anti-depressants, 41% of people with depression said they favoured psychotherapy over taking anti-depressants, but 31% said they preferred to take anti-depressants. The study also finds that patients prescribed with anti-depressants had concerns about adherence to their medication because of the side effects of the drugs. Participants with a university degree said they were more likely to prefer using psychotherapy against those with less education.

There are several theories associated with beliefs and behaviours about medication, for example Horne's theoretical model. He stated that adherence to anti-depressants is influenced by the patient's mental view of whether treatment is necessary and whether it will cause side-effects (Horne, 2003).

There is a difference between general medicine beliefs and specific medicine beliefs that some patients exhibit. If the focus is on the anti-depressant, there are two specific perspectives for beliefs: necessity (the patient's observed requirement for the medication); and concerns (the patient's perceived likelihood for the medication to cause harm). The patient balances the

advantages of taking the medication relative to the harm by assessing a necessity-concern discrepancy; and, therefore, the extent of the adherence determined by these two concepts (Horne, 1999).

To help providers, Aikens et al., (2005) translated the necessity-concern differential into a categorical perspective by splitting both belief dimensions at the median such as, accepting, ambivalent, sceptical and indifferent.

In the accepting group, the level of the adherence is significant compared to the patients in the other three groups. Patients in the ambivalent and accepting groups exhibit significantly more adherence than the patients in the sceptical group. The indifferent group show no significant difference in adherence compared to sceptical patients. The authors found adherence is greater within individuals whose perceived need for anti-depressants exceeds their concern about taking them, and lower for individuals whose concern about taking treatment exceeds the perceived need.

Several influences were analysed to assess the factors affecting beliefs about the treatment such as demographics and social factors. However, Aikens et al., (2005) concluded that the beliefs about necessity for and concerns about treatments for depression were the only variables that accounted for adherence, and these were the most important variables that influenced adherence. Nonetheless, multiple linear regressions were carried out by Brown et al., who revealed that, as well as concerns about anti-depressants, the severity of the depression has an impact on adherence. Furthermore, they identified that individuals who fail to remember to take their treatments had more fears about: taking the anti-depressants; the effect of drugs on them e.g. poisons, do more harm than good; and becoming more dependent on them (Brown et al., 2005).

A study by Bradley et al. (2010) that studies high school, adult and adolescent students, finds that 48% of the participants did not favour anti-depressants as a treatment for depression due to their side effects. One drawback of this study, however, is that the participants self-reported the symptoms of depression using a questionnaire, and this did not necessarily mean they had received

a diagnosis of depression from a professional, or that they had depression at all. Furthermore, in a national survey by Jorm et al. (2005) conducted in Australia, most people perceived anti-depressants as harmful but they also said that depression is one of the less serious mental illnesses. Those surveyed did not show strong concerns about whether or not anti-depressants are something that people with depression must have. In addition, they said that patients themselves might easily manage their depression. The findings show that the participants did not possess adequate information about the role of genetic factors and other social issues in the onset of depression.

A national survey conducted in Italy in 2013 to assess people's beliefs about treatment for depression finds that approximately 53% of participants believed that anti-depressants are important for people with depression. However, 64% of patients said that anti-depressants are addictive, and 55% said that anti-depressants might cause serious side effects. The authors suggest that the majority of the respondents were aware of the symptoms of depression, but the authors do not explore levels of awareness among respondents about depression, and the authors rely heavily on self-reporting by participants in this study (Munizza et al., 2013).

Van Geffen, et al. (2011) use semi-structured qualitative interviews to assess the beliefs of patients who use selective serotonin reuptake inhibitors in the UK. In this study, half of the patients held positive attitudes about selective serotonin inhibitors and did not feel doubts about taking anti-depressants. The respondents said it was necessary to take anti-depressants to recover from their depression and they felt that their anti-depressants were effective and safe. The participants were also satisfied with the role of the GP in their treatment both during initiation to and continuing use of SSRI treatment; the participants trusted their GPs throughout the process. However, the majority of the participants in this study were either unemployed or retired.

When Mardby et al. (2007) undertook a cross sectional study in Sweden of patients who had chronic diseases, patients endorsed negative beliefs about anti-depressants. Patients also endorsed negative beliefs about drugs used for chronic physical disorders and 46% of patients raised concerns about the length of time they had to take medications. The patients who took medications for chronic illnesses were keen to be reassured that their medications are not addictive and that they were safe. However, in comparison with the general Swedish population, university level education are over-represented.

Chakraborty et al. (2009) recruited participants from a multi-speciality teaching tertiary hospital that provides major services in areas of North India and 88% of patients were concerned that anti-depressants could change ones' personality. More than 36% of patients believed that anti-depressants were addictive, but the main demographic of those studied was unemployed people who may not possess knowledge about anti-depressants. However Kessing et al. (2005) also find that patients can believe that anti-depressants alter the personality. In this study, conducted in Denmark, 43% of the patients felt that anti-depressants might alter their personality and 56% agreed that they might become addicted to anti-depressants. These kinds of beliefs might influence patients not to take anti-depressants.

Banerjee and Varma's 2013 study finds that beliefs about mental illness do not vary significantly cross culturally. The authors' cross sectional study uses adult patients who visited a psychiatric outpatient department as participants. In the study, 72.5% of patients believed that anti-depressants are addictive, and 81.3% said their illness got worse after taking anti-depressants. However, the authors stress that the patients in this study lacked full awareness of their diagnosis. For example, some patients reported knowing about the symptoms they received treatment for but not the exact details of their illness. Therefore, they could not comprehend the explanations offered entirely. Nevertheless, the majority of participants had some education. In contrast, Aikens and Klinkman's (2012) study finds that acute patients belief in their medication increased

positively over time as they gained experience using it. However, patients who took part in the study received follow-ups every two weeks. In this study, any concerns the patients had about the harmful nature of anti-depressants reduced after treatment during the acute phase had proceeded. Therefore, the authors of this study suggest that improvement in functional health can possibly change beliefs about treatment.

To summarise this section, patients make decisions based on what they perceive to be the risks or the harmful nature of their medications. Beliefs about necessity influence patients' adherence to anti-depressants. Nonetheless, the evidence suggests that the reductions in the fear of anti-depressants happen if the pharmacist can help to reassure patients and eliminate their concerns. However, this means that pharmacists must be skilled, confident and willing to help people with depression. The next section will explore the attitudes of pharmacists working in the pharmacy.

2.4 Pharmacist Related Factors

In order for pharmacists to be able to deliver their advice to people with depression appropriately, they should possess the knowledge, attitude and skills to consult these people confidently (NICE, 2009 B).

2.5 Collaboration with other health care professionals

Rigby (2010) argues that although the majority of pharmacists demonstrate good practice in primary care, there is evidence to suggest that greater collaboration by pharmacists with other health care professionals can improve patient care. Rigby suggests the use of MUR to improve services. Rigby describes how, in the 21st century, the role of community pharmacies are changing. In addition to dispensing, pharmacists are now required to provide professional advice. According to the Pharmacy Guild of Australia (2010) this change is occurring because of the increased need for pharmacists to

collaborate and engage with GPs and other health care professionals more frequently. However, Latif et al. (2013) suggests that many patients are not familiar with the existence of the MUR and neither do they understand its purpose. The authors find that professionals do not perceive MUR as a collaborative activity with GP services. Rather, when patients do have knowledge of the MUR, they think it is a quick pharmacy orientated check of medicines. The authors find that although GPs often signpost patients to their pharmacies, MURs are not initiated using this route and MURs are usually organised on an ad hoc basis by pharmacists. Latif et al. also explain that pharmacists lack adequate resources to implement MURs, and pharmacists do not experience regular dialogue with GPs in order to implement the service properly. A study by Youssef, et al. (2010) focuses on two pharmacies that share client characteristics in terms of levels of affluence in the patient catchment area and the volume of prescriptions dispensed. This study uses a series of semi-structured interviews and fifteen interventions that address patient perceptions and the side effects of drugs. In the study, 68% of patients said they learnt more about their medications as a result of an MUR, and half the patients learned about the side effects of drugs through the vehicle of MUR; but interviews prescriber pharmacists rather than community pharmacists which may not similar to the current research which are community pharmacists.

When McCann, et al. (2012) undertook a series of interviews with pharmacists, patients and physicians, patients thought of pharmacists mainly as experts in the field of drug interactions, contra-indications and dosage. Additionally, different professionals brought different strengths to the prescribing process and members of an inter-professional team can learn from other professionals. The authors argue that this situation results in better patient care. The only drawback of this study is that it interviewed prescribing pharmacists rather than community pharmacists.

Rubio-Valera, et al. (2012) set up a focus group that included both physicians and community pharmacists recruited from two regions of Spain in order to

evaluate the affecting GP-Community Pharmacist collaboration. The study found that only professionals without previous experience of collaboration proved to hold troublesome attitudes towards collaboration. The health care professionals who had experience with community pharmacists showed positive attitudes towards collaboration. However, in this study the authors note that the two regions compared had different patient to physician ratios and this might imply that collaboration between professionals could vary between regions.

When Lloyd et al. (2010) examined primary and secondary healthcare sectors in Northern Ireland, pharmacists and physicians took part to discuss the benefits of the supplementary pharmacist and the collaborating pharmacist. The physicians reported that supplementary pharmacists are able to improve patient care and the quality of continuity of care. However, concerns were raised about the encroachment of the supplementary pharmacist on the physician's role, but, generally, the participating doctors were in favour of supplementary prescribing, and had already acted as mentors to pharmacists working in this role.

When Patterson et al. (2015) conducted semi-structured interviews with physicians, nurses and other health care professionals, the study revealed different opinions about the benefits of integrating pharmacist services. In patient centred medical homes, some team members reported positive attitudes, while others did not feel that the pharmacist has an important role to play in their team. Some health care professionals had limited knowledge about a pharmacist's training and the responsibilities of the pharmacist's role were not clear. In contrast, the teams who already had experience of collaborating with pharmacists considered the pharmacist to be a core member of the team.

In 2010, Duenas and Pringle published research that studied physicians recruited from different countries in a qualitative study. Their focus group included participants from internal, family and general medicine to assess opinions about pharmacist involvement in medication therapy management (MTM). Physicians noted non-adherence when patients had an incomplete

understanding of their medications. The opinions of physicians about pharmacist collaboration varied between positive and negative, but physicians who already had experience dealing with pharmacists in collaboration reported more positive attitudes towards collaboration. One drawback of this study is that it did not recruit pharmacists into the focus group, and, therefore, the results might have been different with the consideration of pharmacists' opinions.

In order for pharmacists to be able to engage with and deliver advice to patients with depression they need to have the right knowledge, attitude and skills to consult people confidently (NICE, 2009 A).

2.5.1 The Current Work of the Pharmacist

In order for pharmacists to be able to engage with and deliver advice to patients with depression they need to have the right knowledge, attitude and skills to consult people confidently (NICE, 2009 A).

The main role of a community pharmacist is to promote the best use of medicines to achieve a positive outcome. They must tailor advice to individual patient needs and support patients in order to prevent illnesses (Pharmaceutical Services Negotiating Committee (PSNC) 2015). However, previous research has raised questions about the attitudes and motivation of pharmacists to fulfil this role. For example, Cordina et al. (2008) find that community pharmacists are more competent and happy to dispense medicines and manage their workloads but they do not always perceive the extent of their role in pharmaceutical care activities and responsibilities. The authors find that not all pharmacists see themselves as providers of patient care, even though pharmacists often make efforts to improve their communications skills with patients. It is worth noting that the participants in the study by Cordina et al. are a sample of newly graduated pharmacists who might still be optimistic and positive about their vocation in comparison to other more experienced pharmacists.

Due to many different reasons, the extent to which pharmacists practice standard professional responsibilities as outlined in PSNC varies between countries and cultures. However, research shows that the basic role of the pharmacist as a dispenser of medicines and administrator of the ordering and supply of medications is a role understood and practiced internationally. However, many pharmacists prioritise this basic role over medicine optimisation work. In a study undertaken in Indonesia by Hermansyah et al. (2012) it was seen that pharmacists were given scope to place a greater emphasis on non-professional activities, especially those activities that focused on treating medications as a commodity. In this study, the age group of 20 to 30 years of pharmacists recorded higher responses than the middle aged or elderly (53%, 7% and 7% respectively). Therefore, age differences might influence the pharmacist's attitude. Another element of influence is the type of management pharmacists experience in their pharmacies. Dunlop and Shaw (2002) note the idea that age groups demonstrate different attitudes. They report that younger pharmacists are more open to the idea of pharmaceutical care activities than older pharmacists are. In Dunlop and Shaw's study, younger pharmacists are less likely to believe that other professionals do not support a pharmaceutical care role for the pharmacist.

2.5.2 The Attitude of the Pharmacist towards People with Depression

In a cross-sectional survey of community pharmacists by Rickles et al. (2010) undertaken in the USA, pharmacists are seen to be more willing to help patients who have physical diseases rather than mental illness. Some pharmacists studied were uncomfortable discussing symptoms of mental illness, even though the data revealed that these pharmacists had experience of dealing with patients with depression. However, the authors do not outline what type of experience the pharmacists' have previously had, or whether this experience relates to dispensing anti-depressants or training in connection with managing people with depression. When Phokeo et al. (2004) studied a sample of randomly chosen community pharmacies in Canada, the pharmacist participants explained how difficult it is to talk about the symptoms of

depression with patients. The pharmacists who took part in this study said they were less willing to follow-up patients with depression in comparison to other patients who were taking cardiovascular medications, for example. The pharmacists also described their lack of adequate undergraduate training in mental health, and this might account for their increased levels of discomfort when dealing with patients with depression. Pharmacists note a lack of privacy as a reason for feeling discomfort when talking to patients.

After analysing a series of audio recorded pharmacist-patient role play interactions (using simulated patients), Chong et al. (2013 A) conclude that pharmacists are happy to provide advice about the safe and effective use of anti-depressants but less keen to explore non-medical advice or the patient's experiences with depression. The age group of 20 to 29 years showed more openness to undertaking medicine optimisation activities, and 80% of the pharmacists indicated they had the use of a private consultation room. In contrast, in a study by Cates et al. (2005) the pharmacist participants were more comfortable providing pharmaceutical advice to people with depression than to people with cardiovascular disease. However, the authors of this study do not state exactly why their participant pharmacists felt more willing to help patients with depression, although they suggest this might be due to perceptions about the needs of mentally ill patients in comparison to the needs of the physically ill.

When O'Reilly et al. (2010 B) assessed pharmacist beliefs about the helpfulness of interventions for schizophrenia and depression in the UK, it was found that 95% and 91% of pharmacists respectively support the use of psychological treatments and lifestyle interventions. However, 92.9% of pharmacists also support the use of anti-depressants. The research also finds that some pharmacists can provide advice about anti-depressants without being optimistic themselves about the outcome of treatments. The pharmacists generally reported negative opinions about the general long-term outcomes for

people with depression and admitted the likelihood of discrimination against people with a mental illness.

In research by Scheerder et al. (2008), pharmacists expressed positive attitudes towards people with depression. This research assesses the attitudes of pharmacists towards mental illness in comparison with physical illness. In this study, the participant pharmacists were less willing to provide tailored care to patients who had depression in comparison with people suffering from physical diseases. The authors state that the lack of training received by the participants about mental illness may have influenced the results (reported by 73% of the pharmacists). Similarly, in research by Guillaumie et al. (2015) participant pharmacists said they were knowledgeable about depression and could monitor anti-depressants and manage patients. However, again, the participants indicated they were more comfortable talking to patients with physical illness rather than mental illness.

In summary, previous research shows that a lack of training about mental health issues is a problem area for community pharmacists. In several studies, pharmacists are more willing to provide services to patients with physical rather than mental illness. Moreover, pharmacists have many commitments and responsibilities that impact on their ability to spend time with patients generally. The next section will explore pharmacist competencies for building relationships with patients.

2.5.3 Building Relationships with Patients

Worley et al. (2007) find that patients are more prone to change their views about medications when influenced by their peers and friends. Worley et al. also finds that patients regard respect, trust and a caring attitude as important as interpersonal skills. Furthermore, The Royal College of Psychiatrists (2015) recommends that patients should be able to put their trust in their pharmacist because they have received specialist drugs training.

In a study by Riley et al. (2013) it was seen that pharmacists in the UK are more likely than nurses and physicians to respond to the cues and concerns of patients; 81% of pharmacists scored positive in comparison to nurses and physicians (72% and 52% respectively). However, the pharmacists surveyed in this research were 'prescriber pharmacists' who had already learned specialist skills for and had experience of interacting with patients. In contrast, Greenhill et al. (2011) find that community and hospital pharmacists are less likely to be competent in demonstrating the soft skills required for involving patients in a consultation. When Al Ghurair et al. (2012) issued self-reporting questionnaires in Canada to measure pharmacist expertise, relationship quality, patient satisfaction, and relationship commitment, patients viewed their pharmacist's expertise as an important factor for sustaining a relationship with their pharmacist, but one of the limitations of this study is that it uses a convenience sampling technique.

In a study by Liekens et al. (2014), two participant groups were set up in order to assess the communication skills of pharmacists. The intervention group received communication skills training relating to depression whilst the control group did not receive any training. The control group attended a one day depression related training programme that focused on the pharmacists' counselling of unannounced 'mystery shoppers' who had just started using anti-depressant therapies. The study explores the effective outcomes of open questions, and the pharmacists in the intervention group asked more questions about anti-depressants and lifestyle/psychosocial concerns compared to those in the control group. The intervention group had a little information about lifestyle and psychosocial issues but the control group had no information at all. The result was that patients working with the intervention group became more willing to ask questions. However, one of the limitations of this study is that it uses a small sample of respondents. Additionally, when Guillaumie et al. (2015) studied the opinions of community pharmacists working in Canada, pharmacists acknowledged the importance of reassuring and calming patients in order to reduce feelings of guilt. The pharmacists also understood that patients might be

embarrassed to come to the pharmacy to collect a prescription of anti-depressants. The drawback of this study, however, is that it uses a focus group and this might have discouraged the participants from sharing their prejudices about people with mental health problems.

In contrast, Pelicano-Romano et al. (2013) find that pharmacists often assess the quality of their communication according to the quantity of information they impart, rather than on building relationships with patients. The authors suggest that the pharmacists used closed questions in an attempt to overcome the cognitive impairment of patients, especially the elderly patients. In Anderson and Roy (2013), the majority of patients linked the quality of their experiences with anti-depressants to the quality of interaction they had with their physicians, and reiterated that if they have a good relationship with their physician then this facilitates open discussions about the side effects of medication. One of the limitations of this study, however, is that it uses secondary data sources comprising narrative interviews about peoples' experiences of depression rather than their actual use of anti-depressant drugs.

In Guerreiro et al. (2010) patients with physical diseases in Portugal report being satisfied with the quality of interaction with their community pharmacists who demonstrate collaborative care skills with patients. The patients rated interpersonal skills and building relationships highly and they described pharmacists as, 'kind, and very nice'. Building this kind of relationship might help to influence the expectations of patients, and building a degree of trust and familiarity with health care professionals might influence patients to accept pharmaceutical advice. However, some patients in this study demonstrated active resistance when pharmacists tried to give advice, and the patients called on their own knowledge and the higher authority of general practitioners as justification for this resistance. Similarly, Salter et al. (2007) find that patients resist the involvement of pharmacists in their treatment because of attitudes held about the superior authority of GPs. This shows that some patients hold strong views about hierarchies within the health care profession and this can

have an impact on pharmacist relationships with patients. However, in this study the participants were elderly, and had chronic conditions. These circumstances might point to patients having especially strong relationships with GPs.

Gidman et al. (2012) claim that patients are more likely to consult their GPs when they have health related concerns because they are more familiar with their GP as a person and because GPs have more in depth access to a patient's medical history. In this study, patients recorded greater levels of trust with GPs than with pharmacists and said their relationship with their pharmacist was distant.

To summarise this section, building a good relationship with patients is essential when pharmacists intend to deliver advice and information to patients. Trained pharmacists are more able to open up discussions and respond to patient cues, and patients become more involved with pharmacists who can tailor services and build effective relationships.

The next section will explore the quality and quantity of information pharmacists give to patients.

2.5.4 Provision of Information to Patients

Crump, et al. (2011) describe how important it is that pharmacists are able to provide quality information that is tailored to individual patients and be proactive in providing patient-centred care. Additionally, Rosenthal et al. (2010) explains that, in recent years, community pharmacists have been encouraged to take on an expanded role to include giving professional medicine optimisation advice. However, the quality and quantity of information and services provided by pharmacists worldwide can vary. Al-Arifi (2012) explains that in Saudi Arabia the professional role of the pharmacist has improved in recent years. Patients now experience higher levels of satisfaction and have a greater understanding of the pharmacist's role in their health care team. However, the study does not discuss whether these improvements cover both OTC medicines and chronic

diseases. Moreover, Saudi Arabian patients still perceive the main role of the pharmacist to be that of a dispenser of drugs and provider of basic information about medicine. The authors note that some pharmacists lack a private room for consultations and this works as a barrier to providing enhanced services for patients.

When Doucette et al. (2013) undertook research to explore the views of Canadian patients discharged from hospital the study found that nearly half of the patient participants could recall the interactions they had with pharmacists during their time in hospital. Out of the patients who could recall their dealings with a pharmacist, 89.1% said they were satisfied with their interaction and 83.2% said they would accept offers of support given by pharmacists in the future. One drawback to this research, however, is that the study used a telephone survey that was conducted five to seven months after the patient's discharge from hospital, and the long intervening period may have provided patients with opportunity to forget their experiences and the information they were given.

In a study by Pelicano-Romano et al. (2013), community pharmacists spoke more often, and for a longer time than patients spoke during interactions. Reasons stated for this by the pharmacists included: checking their own understanding of information given, and trying to reassure patients. Dickinson et al. (2013) find that many patients prefer information tailored to their health needs and that tailoring information would help to reduce their concerns about diseases and medications. In a focus group of Canadian pharmacists set up by Guillaumie et al. (2015), pharmacists admitted that they did not take active action when patients experienced problems with adherence to treatment. They said they were more likely to provide a brief consultation at the counter to try to improve adherence. The authors suggest that a lack of tools for monitoring therapy is one barrier to providing quality care.

In 2004, Knapp, et al. surveyed patients who attended a cardiac rehabilitation clinic to find out about the risk factors connected with receiving verbal explanations about drugs in comparison to receiving numerical based factual information. In the study, 18% of patients felt they would experience side effects after receiving a verbal explanation whilst only 2.1% reported this perception after receiving numerical based information. However, no differences appeared between groups regarding their decision to take medication. One drawback of this study is that a time gap of a few months had elapsed between when the patients started to take medications and when they reported their responses. Dyck et al. (2005) finds that pharmacists can be imprecise when explaining the side effects of drugs generally, and they often use terms such as 'sometimes' and 'possibly'. The authors suggest that pharmacists might not be fully aware of the frequency of side effects. In this study, it is not clear whether or not the pharmacists use these terms so as not to alarm patients, or to make it easier for patients to understand information.

In a study by Hamrosi, et al. (2014) most of the participant patients were happy to receive advice about the side effects of medication either in the form of a general explanation or in numerical and factual form. The patients in this study indicated they were more likely to overcome their fear of side effects if the explanation focused on the positive effects of the medication rather than possible side effects. Additionally, Displenter et al. (2013) find that pharmacists think it is difficult to discuss the side effects of drugs with patients who take antidepressants, especially when the side effects might be severe, such as weight gain, for example. The authors claim that many health care professionals, including pharmacists, prefer not to tell their patients about the full side effects of drugs because they fear the patient will no longer want to take their medications. One drawback of this study, however, is that the patients used were from a narrow sample of inpatients in a psychiatric hospital. When Kairuz et al. (2013) created a hypothetical patient (scenario) in Australia to test pharmacists' communication skills, the participant pharmacists tended to use the term 'you' frequently in an attempt to personalise information given, and to

try to reassure patients. However, Mohammad, et al. (2014) finds that Australian patients with low English proficiency can be confused and overwhelmed by the large amounts of information included in information leaflets, especially about side effects. Patients studied in the focus group said they relied on professionals for information about medications and other health related treatments. Furthermore, because the patients had not been newly diagnosed this might indicate that pharmacists behave in a paternalistic way with regular patients. The authors also find that pharmacists can behave in a paternalistic fashion with patients when they prescribed new medications. However, one drawback to this study is that it only focuses on ethnic minority groups.

A study by Tarn et al. (2009) finds that older patients can become dissatisfied when pharmacist care providers do not explain side effects to them. The authors also find that there can be disagreements between pharmacists and patients about the kind of information patients expect to get from various health care providers. In this study, some pharmacists felt that physicians should be the ones to explain serious side effects to patients, but that pharmacists can explain mild side effects. To overcome this problem, the authors suggest that pharmacists should collaborate with other health care professionals to facilitate a comprehensive consultation and to reduce overlapping discussions. One drawback of this study however, is that it focuses on elderly patients only.

Crump, et al. (2011) note disagreements about who should give out what information. The authors report disagreements between community pharmacists in New Zealand. In this study, some pharmacists were able to support patients by liaising with other health care providers; this kind of communication is essential for the continuity of care, medicine supply and adherence. Nonetheless, some pharmacists had difficulty in accessing and communicating with other health care providers. Furthermore, some pharmacists said they had limited access to consumer information, which reduced their ability to tailor information to patient requirements and this makes it especially challenging

when trying to tailor mental health information. In this study, the participant pharmacists appear to take paternalistic approach towards patients and do not tailor information to patient needs. They make assumptions about the correct amount of information given and the needs of patients. Explaining side effects is one area of performance weakness recorded. In this respect, pharmacists were less motivated to provide information to patients. However, the lack of an adequate model to use in order to explain the side effects of drugs increased the possibility of withholding information unintentionally.

2.5.5 Engaging the Patient in the Consultation

Watson (2003) explains that concordance is the process by which the pharmacist gains trust from a patient during a consultation, and this process is different from the process of adherence. Concordance incorporates a process of shared decision-making, and stands in opposition to paternalism. The Royal Pharmaceutical Society (2014) reports that patients need to receive advice about medications and about their wellbeing and pharmacists should put patients at the centre of care so that patients receive the benefits of pharmacist collaboration with other health care providers. In addition, pharmacists are responsible for educating and enhancing patient understanding of medicines and health conditions. Worley-Louis et al. (2003) reiterates that a patient centred approach can enhance the quality of pharmacist-patient relationships.

When Liekens et al. (2012) assessed care for patients with depression by Flemish community pharmacists, they found that pharmacists were not confident to discuss depression and its treatment with patients, and pharmacists lacked the skills to offer quality consultations to patients. More than half of the participants said they only had basic skills in psychosocial communication. Similarly, in a study by Crockett and Taylor (2009), Australian pharmacists did not encourage patients into discussion, and the participants said they lacked knowledge to give proper advice. Participant pharmacists were concerned about giving the wrong information to patients. However, this study focuses on

a small sample of community pharmacists. A study by Desplenter et al. (2013) supports these findings; this study uses semi-structured interviews to assess practices for giving out information about anti-depressants to patients. The pharmacists who took part in this study said it was difficult to engage patients when discussing the negative actions of anti-depressants and this encouraged the pharmacists to take a paternalistic approach.

In a study by Street et al. (2007) the participant physicians were patient-centred and conveyed positive emotions toward patients. As part of the research test, physicians were unaware that some patients needed more support. The pharmacists were successful in providing advice without patients having to state their problems, and the pharmacists displayed knowledge without giving out unnecessary information. In a study by Salter et al. (2007) of elderly patients who had undergone a home medicine review, some elderly patients rejected offers of advice from pharmacists. This might indicate that the negotiation of patient agendas must happen in the structure of the consultation. The drawback of this study, however, is that it only studies people with physical diseases.

Malpass et al. (2011) note that patient agendas often remain unvoiced due to mutual misconceptions and because patients, pharmacists and GPs hold traditional views about the role of the pharmacist and the physician. Some patients believe that physicians are more knowledgeable about anti-depressant drugs than pharmacists are. GPs feel they are more knowledgeable than patients are, and, sometimes, GPs can overestimate the patient's own sense of autonomy. One drawback to this study, however, is that the sample size is small. Similarly, when Pelicano-Romano et al. (2013) studied how patients engage with community pharmacists, the pharmacists spoke more often than the elderly patients did during interactions. However, the study uses audio-recordings, and does not explore non-verbal cues, so this might serve to limit the contextual depth of the data analysed. In a similar kind of study by Dyck et al. (2005) pharmacists relied on one way communication with the patients during discussions and patients responded frequently with short one syllable

answers 'oh' and 'okay', but it was not clear whether the patients understood the pharmacists' explanations or whether they were just acknowledging the pharmacists words. However, in the study the participant pharmacists did not stop to check the patients 'understanding but continued with their explanations, and just assumed that the patients had heard the information.

A study by Boeni et al. (2015) confirms that the majority of community pharmacist-patient interaction still focuses on giving out advice about medication administration and dosage. The quantifiable results after observation using a checklist showed that nearly 6% of patients received counselling about adherence but that pharmacists did not engage with patients. The pharmacists used closed questions when consulting with patients and this behaviour limited the involvement of patients in making decisions about their treatment. The authors suggest that pharmacists must consider the patient's beliefs and views, but the patients visiting for OTC and prescription medicines faced a series of closed questions. Similarly, after an analysis of twenty eight to thirty five consultations, Britten et al. (2000) recorded high levels of pharmacist-patient misunderstandings. The majority of misunderstandings happened because patients had to listen passively to pharmacists.

2.5.6 Summary of the Literature

Non-adherence to anti-depressants is considered a serious issue, and there are many different reasons for both adherence and non-adherence. In this study, the pharmacists lacked the competency/confidence to build-up relationships with patients, mainly because they may demonstrate paternalistic behaviour towards patients. This inability to create good relationships with patients meant that the participants were less able to engage into mutual discussions with patients in order to improve adherence. This inability to facilitate the mutual sharing of information between patients and pharmacists contributed towards 'building barriers' that prevented the participants from tailoring information to meet the needs of patients.

In this study, the researcher explored the performance of community pharmacists when offering consultations to people with depression. The study aimed to encourage participant pharmacists to reflect on their practices and assessed the outcomes of this reflection activity on patient satisfaction levels.

Chapter 3 Aim and Objectives

In order to enhance the quality of care provided to patients, it is essential to evaluate the current work of the pharmacist and their ability to establish mutual discussions with patients. Moreover, encouraging pharmacists to reflect to their practice when they provide services enhances the patients' awareness of pharmacist competency.

3.1 Aims and Objectives of the Study

The main aims of the investigation were:

1. To evaluate and increase community pharmacists' willingness and ability to perform an initial consultation for patients with depression; and
2. To assess any changes that have taken place after intervention which relate to the patients' views about satisfaction experienced.

To achieve the aims, the specific objectives are as follows:

1. To explore ideal levels of service, and to develop a suitable scenario for simulated practice;
2. To explore pharmacy students/pharmacists' existing prior knowledge and attitudes with respect to depression and its treatment;
3. To determine the extent of patients' satisfaction with their pharmacists;
4. To observe and assess the skills of the participant pharmacists;
5. To obtain feedback by means of interviews with participant pharmacists after the simulation sessions;
6. To encourage the participants to increase the level of service they provide in their practice by making an 'action plan'; and
7. To assess the impact of any changes made to service provision on patient satisfaction.

3.2 Methodology and Methods

3.2.1 Introduction

The general aim of this research was to improve the consultations provided by community pharmacists for people with depression. The study consists of mixed quantitative and qualitative methods. Qualitative investigation is exploratory in nature. It aims to achieve an understanding of underlying opinions, beliefs and reasons. Qualitative study is well suited to explain phenomena within their context. The analysis of qualitative data can provide insights into a problem to promote ideas or hypotheses for potential quantitative studies. Qualitative methodology attempts to explore issues in depth and data collection methods vary from observation to interview (Dingwell and Murphy, 2003). Compared to quantitative methods, the sample sizes in qualitative research studies are small. Generally, recruitment for qualitative studies is considered sufficient when new participants no longer generate new ideas or add to prior understanding (so called 'data saturation') (Green and Thorogood, 2004). The next section will provide a more detailed explanation about the reasons for choosing qualitative methods and the tools used to analyse the qualitative data.

Well-specified problems can be studied using quantitative methods by generating numerical data that can be analysed descriptively and statistically. Quantitative data collection methods are characterised by their structured nature, in comparison to qualitative methods. Quantitative data collection does not tend to explore in depth reasoning or underlying assumptions. There are many examples of quantitative methods including structured questionnaires (for administration or self-completion) and experiments (for example, controlled trials). Even though quantitative investigations tend to use numerical variables and qualitative investigation tends to produce language data (written or oral) this difference is not always apparent. Quantitative investigations can produce

language data and qualitative studies can produce frequency counts. There are some methods used for data collection in quantitative studies (such as interview), which can also be used in qualitative studies. Therefore, it is not only the type of methods or kind of data that characterise quantitative or qualitative methodology but also the nature of the question. Qualitative studies tend to ask questions such as 'Why?' or 'How?' rather than 'How many?' or 'How much?' which are associated with a quantitative approach. Thus, qualitative studies can be exploratory prior to quantitative studies; they can aid the understanding quantitative findings or used in parallel with quantitative studies to understand phenomena in depth (Dingwell and Murphy, 2003).

3.2.2 Theoretical Perspectives

Positivism is a philosophy of science that proposes that one reality exists, and it exists in an exact way whether people understand it or not. People might have different interpretations of reality, but according to positivism, reality is stable and independent of the subjective ideas of people (Green and Thorogood, 2004).

This study uses objective methods to assess the performance of community pharmacists when they interact with people with depression. The first method used was to assess the knowledge of the community pharmacists' management of depression. This includes their awareness of the actions and safety of anti-depressants. This enabled the researcher to get feeling about that what the community pharmacists know, if they can provide information that can maximise the efficacy of treatment, and reduce the negative actions of medications. The second method used was to assess the attitudes of the pharmacists towards depression and the treatment of depression, and attitudes towards the role of the pharmacist and towards people with depression. The third method used assessed the competence of the pharmacists and included an assessment of the quality of information given out, and the behaviour of the pharmacists. A satisfaction questionnaire was used to assess the satisfaction of patients with

service provide by the pharmacists. All these methods employed using objective measurements.

Positivism is suitable if the researcher is aiming to understand the behaviour of people. Natural science is inappropriate for studying the behaviour of people because the behaviour of people is unpredictable and contextual. Individuals make their own sense of their place in world, and they are more likely to change their behaviour when being observed. In order to understand how people interpret reality, observation sessions were used (Green and Thorogood, 2004). When the researcher assessed the views of participants, it was essential to remember that the participants might seek to justify their behaviour rather than express their deep beliefs (Dingwell and Murphy, 2003). The range of the interviews that can be used in research vary from structured, semi-structured to an un-structured form. Themes are then generated from interviews are either descriptive (numerical) or counts. Green and Thorogood state that structured interviews involve distributing structured questionnaires and interviewers have to ask pre-planned questions in a similar manner and sequence. This type of interview elicits objective facts from the respondents. Moreover, the researcher should stick strictly to the script to avoid any differences in self-presentation or changes in behaviour from the interviewees that might bias the responses. Thus, this technique of eliciting the information was not suitable to for use for understanding the perspectives of the pharmacists due to patients' fixed responses (Green and Thorogood, 2004).

To expand the scope of interviews, semi-structured interviews strike a balance between the structured and unstructured interview. In the semi-structured interview open-ended questions are used which allow a certain extent of flexibility for the interviewee to answer. Thus, the researcher can make use of cues and prompts to assist and guide participants into the research topic area. In this research after observing the pharmacist-simulated patient consultations, interviews took place with the participant to elicit more information. Interviews enable the researcher and the pharmacists to interpret their current practices, and the responses included opinions, beliefs and their intentions when

consulting people with depression. This provided rich and in depth data and encouraged the participant pharmacist to reflect on their consultation.

Another approach used in qualitative research is the constructivist approach. This assumes that reality is socially constructed rather than clear understood. People construct their own understanding of the world, through a historical and social process. People tend to reflect on what they believe and perceive compared to new experiences, and, so they might gain new experiences and so change, or they may maintain the same perspectives and behaviours (Green and Thorogood, 2004).

After the observations and interviews, an action plan designed, based on the pharmacist and patient consultations. Pharmacists were encouraged to construct their practices towards their learning needs. This helped the pharmacist reflect on the observation and their interview as it applies to real life.

3.2.3 The Approach Used to Underpin Mixed Methods

Mixed methods are the research tools used in the current research. The mixed methods approach places emphasis on gathering and analysing data, and it is about mixing both qualitative and quantitative data in a single research. Combining both methods makes for better understanding of research issues than using one approach alone (Creswell and Clark, 2011). The flexibility of mixed methods approach provides the researcher with practical ways to address a research question. Moreover, flexibility enables the researcher to use numeric and textual data.

Using mixed methods combines inductive and deductive approaches, which enables researchers to use different tools for gathering data, rather than focusing on one technique (Creswell and Clark, 2011). A deep understanding of phenomena broadly results from analysing qualitative data, whereas quantitative data provides general results. Different pictures or perspectives arise from doing qualitative and quantitative research, and both of them have limitations. When doing qualitative research it might be hard to generalise the

findings, whereas quantitative approaches diminishes the understanding of any individuals under investigation. Inadequacy of data may arise because one type of method may not provide the full story, or the researcher may lack confidence in the ability of one type to address a complex problem (Green and Thorogood, 2004; Creswell and Clark, 2011).

In the current research, it was not thought possible to achieve a thorough understanding when using questionnaires to assess the practices of the pharmacists, so it was worth using qualitative methods to understand why the pharmacists behaved the way they did. This enabled a better assessment of pharmacists' ability to place patients at the centred of the consultation.

The methods used in the pilot and main stages were similar. They are therefore, explained as a single set of methods, but differences and necessary adaptations are highlighted.

3.3 Methods of Data Collection Used in the Study

Figure 3.1 describes the initial stage of this project when the research intended to build up these methods to assess the current practice of community pharmacists. This stage includes piloting with pharmacy sandwich students (with intercalated training periods) and practitioners who contributed by giving feedback about their experience in practice, and the usefulness of these methods to encourage other community pharmacists to reflect on their practice. The second stage **Figure 3.2** includes main methods in which the researcher applied these methods with community pharmacists (participants) and also assessed patients' experience with service provided in the pharmacy.

Methods shown below comprise three stages, as explained in the flowcharts for the pilot (**Figure 3.1**) and the main study (**Figure 3.2**).

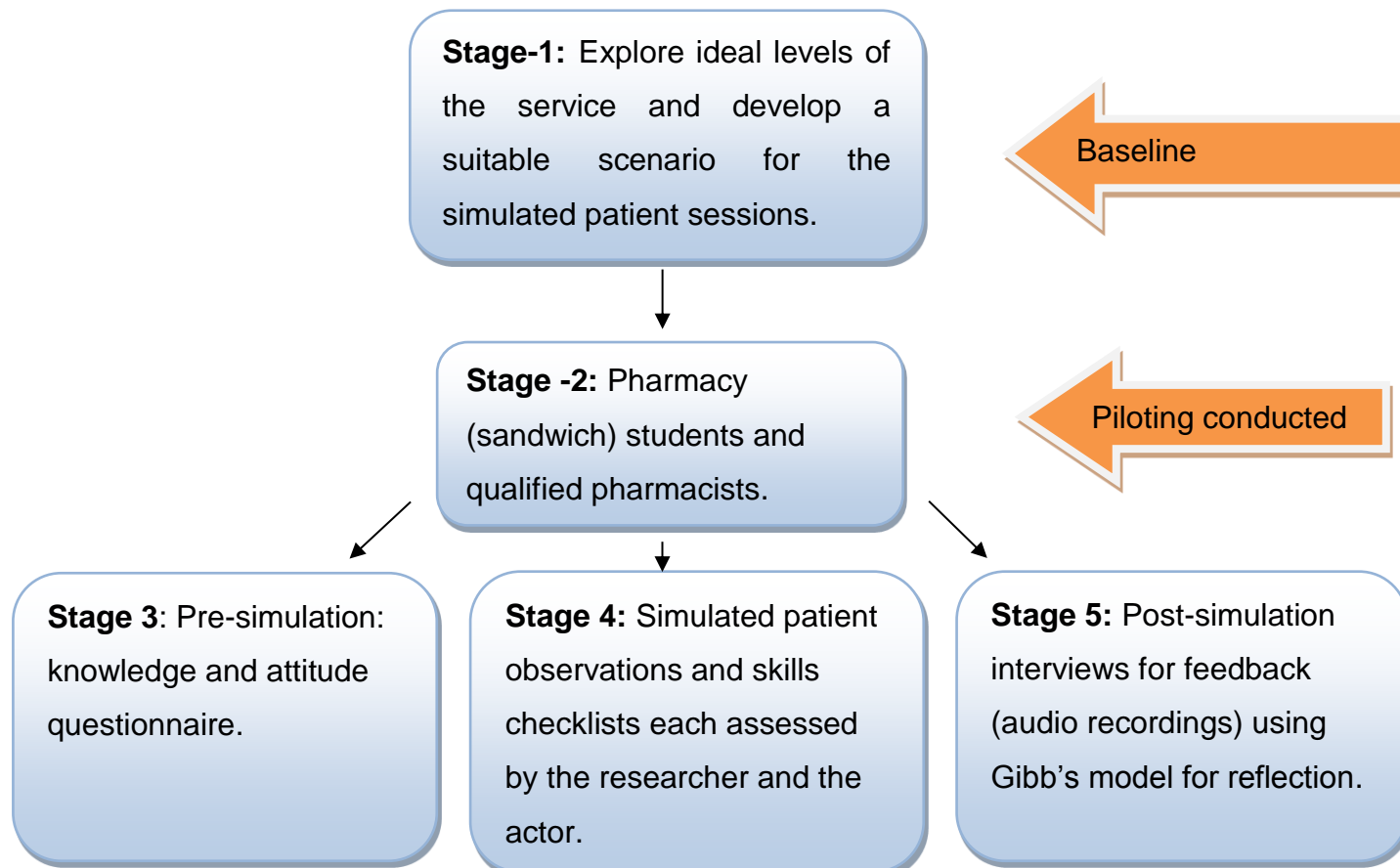


Figure 3.1: Flow diagram showing the procedure used in piloting

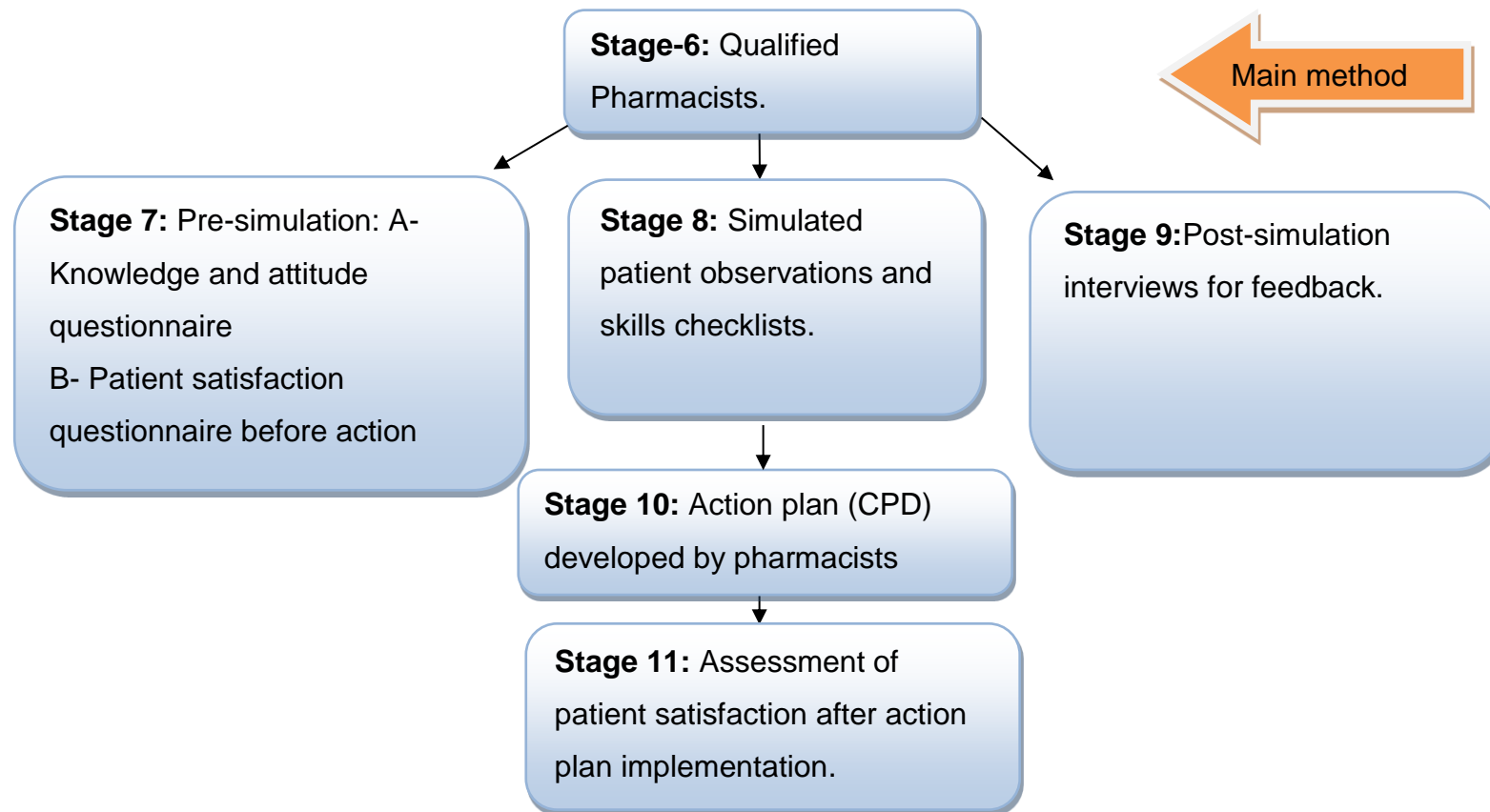


Figure 3.2: Flow diagram showing the procedure used in the main method

The methods used in the pilot and main stages were similar and are explained as a single set of methods, but differences and necessary adaptations are highlighted.

3.3.1 Ideal Levels of Service Explored

The researcher searched previous research to find gaps in order to build up the methods. The search assessed the extent to which needs of patients were met by the community pharmacists. Patients are good indicator of quality and safety and are part of the treatment plans that health care professionals design.

People Recovering from Depression

In the past, clinical treatments offered to patients depended only on formal clinical assessment by health care professionals. However, the patient's background and personal experience are now considered important factors in clinical decision-making (NICE, 2012 A). Furthermore, patients have regularly been engaged in independent advisory groups to evaluate care provision and make recommendations for changes in practice (NICE, 2012 B). Patient involvement focuses on aspects of health services that need to undergo change to enhance the quality of care, which includes increasing clinical and cost-effectiveness. Patient experience is complex and multi-faceted. Factors associated with individual satisfaction include beliefs, social situation, ease of access to health care services, and relationships with health care providers.

This range of factors provides opportunities to influence the patients' experience of care, in order to facilitate shared decision-making (NICE, 2012 B). The above explanations carry two ideas. The first idea is the journey of patients when they experience depression and receive treatments, and the second idea encompasses coping mechanisms patients use to get relief. These two ideas provide the researcher with information about the difficulties people face when they are undiagnosed and how difficult it is to find support from health care professionals and/or their relatives. The second idea focuses on the motivation of patients to get relief where they lack help from health care professionals. This

information may enable the researcher to explore patients' behaviour in relation to the current practices of community pharmacists.

Therefore, the researcher began with a discussion with patients. The researcher had an exploratory discussion with a person who had a history of depression and was an employee at the University of Bradford. The aim of the discussion was to explore the most important information about the depression and its treatments. This colleague subsequently collaborated with the work. He is experienced in acting, and was willing to play the role of a simulated patient in a simulated scenario. During the initial discussion with the actor, the researcher focused on the information associated with the patient-pharmacist interaction. Furthermore, the discussion highlighted the interaction of the patient with a physician. The researcher also attended an undergraduate teaching session presented by a patient who had received treatment for depression and has lived with the condition for few years. Notes from the researcher exploratory discussion and the teaching session helped to outline the most important information to support scenario development for the simulated patient sessions.

The Medical Charity 'Mind'

To reflect the importance of patient experience when developing health care services (NICE, 2012 B), Further discussions was with people associated with 'Mind' (a charity and self-help organisation for people with mental health problems). These patient advocates had experience of depression and its treatment, and they were actively engaged (through Mind) in self-help and helping others.

The researcher attended a regular meeting of a recovery group to explain the researcher (tentative) research plans and seek feedback about the scenario for simulation (Appendix-4). The group also volunteered information about their experiences supporting patients in recovery, their attempts to encourage positive thinking, and support mechanisms for people with depression. The interview gathered more information about unmet needs when patients meet

with community pharmacists. Moreover, this interview helped me to realise patients' expectations about the pharmacists' responsibilities. The researcher took notes even though audio recording would have been a better method to use, but due to ethical issues, the researcher manually wrote the down the patients' experiences of the service, the behaviour of the pharmacists in the pharmacy and the extent of the support by received pharmacists. This informal interview guided the researcher towards establishing the scenario when observing simulated patient sessions with the community pharmacists (explained later in more detail). Moreover, this interview was one approach that helped the researcher assess the satisfaction questionnaire.

Professionals

A final round of informal discussions took place with three pharmacy practitioners who had experience caring for people with depression and another mental health conditions. This was to elicit more information about the treatment of depression, typical patients and preferred consultation styles (Appendix-5). During the discussions, the practitioners raised concerns about their ability to constructively elicit and use personal information about patients. The practitioners were concerned that eliciting personal information might make the consultation uncontrollable. The concept of stigma is important when patients are collecting their anti-depressants from the pharmacy. With regard to the behavioural skills of pharmacists, these practitioners talked about their personal experiences and held a general view that some pharmacists were not fully competent to hold consultations for people with depression.

The interview was informal, and was mostly about the current practices of the community pharmacists. The researcher focused on mental illness, and, especially people with depression. The discussion covered the willingness of the pharmacists as well as barriers to satisfying the needs of patients. Again, the researcher took notes because of ethical issue relating to the recording of interviews.

NICE Guidelines

The NICE (2009 A) guidelines provide the expected standard of care for pharmacists and other practitioners. This ranges from screening and diagnosis to initial treatment and follow up. For example, if a professional suspects a patient is at risk of depression, then he or she can use screening questions to verify the need for referral or further assessment:

- 'During the last month, have you often been bothered by feeling down, depressed or hopeless'?
- 'During the last month, have you often been bothered by having little interest or pleasure in doing things'?

The NICE guidelines consistently use the term 'practitioners' to refer to members of the multi-disciplinary team. In some cases NICE specifically mentions specialist practitioners and their roles. However, in most cases the practitioners referred to could be doctors, nurses, pharmacists or indeed other professional carers. The guidelines influence any professional who has direct clinical contact with adults with depression. It is up to each professional to judge the extent of their involvement in shared decision-making and develop their competence appropriately. Arguably, the role of pharmacists is under-developed, because the profession fails to appreciate its role helping to implement quite general guidelines. However, pharmacists can develop roles in accordance with NICE recommendations, their own competencies and patient expectations. The scenario developed reflects these assumptions (NICE, 2009 A).

The trend of best practice is to enable patients to guide the clinical decision. NICE (2009 A) describes the competence of practitioners who deliver services to people with depression. The guidelines consider the balance between the practitioners' ability to choose suitable anti-depressants and empower patients to take decisions about their treatments, whereas NICE (2012 B) focuses on the patients' autonomy and legitimacy. The guidelines aim at encourage

professionals to make patients the owners of their treatment and enable them to make decisions about their health conditions.

These guidelines provided good knowledge to the researcher about the standard of practice of care the pharmacist should practice. They also provide more information about the responsibilities and the extended role of community pharmacists. This helped the researcher to build an idea about the next scenario. The responsibilities of the pharmacists are not limited to advising patients about medications but screening patients at risk and engaging them into mutual discussion.

Pharmacists who meet with people with depression and other professionals often results in patients who are less satisfied with the services provided by the pharmacist. Limited time, not engaging patients in discussion, and being unaware of the private consultation room, leads to low expectations about the role of the pharmacist. The interviewed professionals also outlined the difficulty when managing people with depression, especially when stigma attaches to these patients. It started to become clear that the recommendation by NICE, as described earlier, are not practiced generally by the community pharmacists. This encouraged the researcher to establish the scenario to achieve more feelings about this issue by means of surveying patients and professionals.

3.3.2 The Scenario for Pharmacist-Patient Consultations

The aim of the research is to enhance the willingness and confidence of the pharmacists to hold consultations for people with depression. Participating in a simulated scenario is one of the tools used to assess the competency of the pharmacists and provide feedback to them about their current practice. Running the scenario helps the researcher and the pharmacists to work together to explore shortcomings in the service delivered and identify steps needed to improve patient consultations. The simulated scenario developed was a short plot for the actor who played the role of 'patient' (Appendix-6). The scenario comprised:

- Patient demographics (for example, age and gender)

- Causes and symptoms of depression
- Treatment recommended by a medical general practitioner
- Social and lifestyle factors

When first developing the scenario, the plan was that the actor should not tell the pharmacist his diagnosis, so that the pharmacist tried to elicit this information. However, not revealing the condition did not necessarily assess the competency of the pharmacists, because some symptoms of and treatments for depression were similar to anxiety. This adds to the complexity of the scenario in the absence of a detailed medical history or personal experience with the patient. In real practice, my thought was that not revealing the diagnosis of depression would probably result in one of two actions: either pharmacists would give the medication to the patient without consultation; or pharmacists would try to provide general advice to avoid any mis-direction.

A study by Guirguis (2011) conducted in the USA to assess the importance of using three prime questions (3PQs) when pharmacists communicated with patients in the pharmacy uses self-report surveys and focus groups to assess the perceptions and belief of pharmacists about the 3PQs. In the study, patients felt comfortable and were able to interact with the pharmacists who found positive reactions and were more involved with the patients. Reflecting on the findings of Guirguis (2011), if pharmacists are certain about the patient diagnosis, then they should ask the following questions:

- What did the doctor tell you to use this medicine for?
- Or, do you know what this medicine is for?

A third question was excluded 'This antibiotic has several uses. What are you treating?' This question was more suitable for physical illnesses rather than mental disease. Antibiotics treat infections for different conditions such as, infection in the chest or gastro intestinal system, unlike anti-depressants that are more likely to work in the brain. Nevertheless, clinicians sometimes do not tell the patients the purpose of treatment (Grimes and Barnett, 2014). Probably if patients did not know the purpose of anti-depressants, pharmacists could screen patients for depression.

The scenario was from different sources such as NICE Guideline (NICE, 2009 A), my professional experience, and the discussions outlined above in 3.3.1. To set up the simulation, a prescription template was prepared for “Sertraline 20 mg, once daily” and a dispensed pack was prepared. The prescription and dispensed pack added to the realism of the scenario, which took place in a purpose built room fitted out as a small community pharmacy. A computerised patient medication record (PMR) was available so that pharmacists could review the history of the patient. If the pharmacist offered the patient a private consultation, then suitable space was available to sit down. The action moved from the initial meeting space beside the dispensing bench to the consultation room. This action of offering confidentiality can encourage the patient to talk more comfortably, and the availability of consultation space provided further realism for the pharmacists.

The researcher asked the patient to behave in a normal and neutral manner during the consultation, and not try to ‘test’ the pharmacist. However, the researcher mentioned that patient could ask appropriate open or closed questions if he felt that the pharmacist did not cover the information required, for example, side effects or the duration of treatment. The patient had experience of depression (as mentioned previously) and he could ask as many questions associated with the medicine or other non-medical treatment. Nevertheless, we hoped the scenario would be suitable and match what happens in real practice.

3.3.3 Pharmacists’ Knowledge of People with Depression

NICE guideline (2015 B) outlines the importance of pharmacists’ knowledge as one of the factors for improving patient health care. However, it was difficult to find any framework in the literature to assess pharmacists’ knowledge with helping people with depression. Many questionnaires exist to assess the knowledge of pharmacists but they are not adapted for the reasons shown below.

One study emphasises the practicality of the services to assess the knowledge of pharmacists, for example, the best method of supplying the medicine and presenting the information on the medicines (Hanafi et al., 2013). Another questionnaire was designed to quantify the side effects, and the reasons for under-reporting them by pharmacists (Khan, 2013). Explaining side effects is an important part of the advice, but pharmacists should provide other information about anti-depressants. The researcher asked some pharmacists who work as colleagues at the University of Bradford if they knew of any framework to assess pharmacists' knowledge about depression and anti-depressants, but we did not find any such framework.

A hand search of resources from the Royal College of Psychiatrists (RCP) took place. The RCP is the leading professional organisation for mental health care. An RCP information leaflet was then adapted to create a survey instrument to assess pharmacists' knowledge about depression and anti-depressants. The RCP (2012) (Appendix-7) states that their information leaflet is suitable for patients who are recovering from depression and for anyone seeking further information about anti-depressants. Implicitly, this means that pharmacists can safely deliver advice and information to patients as explained in this leaflet; pharmacists do not necessarily have to provide all the information in the leaflet, but can tailor verbal information to the patients' needs. Patients often prefer tailored verbal information, alongside or instead of simulated written information (Dickinson et al., 2013). Although the information in the RCP leaflet is intended for the general public, similar basic information is found in NICE guidelines (NICE, 2009 A). NICE guideline states that practitioners should explain fully the reasons for prescribing and providing information about taking anti-depressants; this includes anticipated side effects and the gradual development of the full anti-depressant effect.

Landers et al (2002) show that the questions patients ask pharmacists about depression and anti-depressants are similar to information provided by the RCP and NICE. There is, therefore, broad support for the questions in the survey instrument that developed for this study.

The RCP leaflet was specific to anti-depressants and reviewed to highlight the most important content in relation to pharmacy practice. Excluded questions as listed below were less important in the current context. The aim was not to examine how pharmacists would answer all possible questions associated with depression and anti-depressants. The excluded questions were:

1. What kind of anti-depressants have I been recommended?
2. Do anti-depressants affect pregnancy?
3. Do anti-depressants affect breast-feeding or breast-fed babies?
4. What if the depression comes back?

If necessary, pharmacists can answer these questions from information provided in the British National Formulary (BNF). They are important but do not directly apply to the majority of patients starting an initial course of anti-depressants. When relevant, answering these excluded questions requires medical judgment (from GPs or psychiatrists), to determine the appropriateness of prescribing. Nevertheless, pharmacists have a vital role to signpost patients and suggest solutions to clinicians. The help pharmacists can provide is supported by NICE (2012 A), and pharmacists should discuss other optional treatments for people with depression such as psychological or social support. Moreover, pharmacists should offer help and information to patients and guide to sources of support.

Some studies have found that pharmacists can find it difficult to decide which treatment is suitable for patients. Gawley et al. (2011) carried out an investigation in Canada to assess the opinion and knowledge of medical and pharmacy students. The investigation focused on pregnant women with depression. Medical students knew significantly more than the pharmacy students did about the effects of depression on the foetus, as well as the safety of anti-depressants during gestation. In my personal view, medical students study the effects of diseases on the human body more broadly than pharmacy students, and thus, medical students are more able and confident when

deciding if prescribed anti-depressants are suitable (or not) for patients with particular needs or co-morbidity.

Nevertheless, if pharmacists collaborate more with clinicians this would promote the effective use of medicines. Al-Aqeel et al. (2012) studied the experience of psychiatrist interaction with pharmacists in Saudi Arabian hospitals. They found 77% of psychiatrists expected that pharmacists were able to take responsibility to resolve any issues related to anti-depressants, and 75% agreed that pharmacists could educate people with depression about safety and optimal use of anti-depressants (Al-Aqeel et al., 2012).

Questions and information from the RCP leaflet on anti-depressants underwent modification to allow option selection or semi-structured responses. This was to facilitate ease of completion (by pharmacists) and ease of analysis (by the researcher).

3.3.4 Pharmacists' Attitudes towards People with Depression

A further questionnaire was adapted and developed to assess the attitudes of pharmacists towards patients with clinical depression (Appendix-8). Although some pharmacists offer information and advice to patients with depression, they are not convinced that the condition is treatable. The attitude of the pharmacist plays an important role in providing services to patients. Some pharmacists provide advice about anti-depressants without being optimistic about the treatment outcomes. O'Reilly et al. (2010 B) conducts an Australian survey to assess pharmacists' beliefs about the helpfulness of interventions for depression. The percentage of pharmacists who preferred psychological treatments and lifestyle interventions was 95%, whereas 92.9% preferred anti-depressants. The pharmacists showed positive attitudes towards both anti-depressants and counselling for the treatment of depression, although, statistically, counselling scored higher. The scenario did not show if the patient had been on a medication for a long time, or any previous failure to take anti-depressants. The presented cases were more likely of mild to moderate

symptoms, and this could explain the pharmacists' preference of counselling over anti-depressants.

In line with NICE (2007) pharmacists who have positive attitudes towards depression and people with depression, have positive feelings towards the consequences of intervention for these patients, the outcome of this positive attitude could increase adherence to anti-depressants or promote patients coping with their symptoms effectively.

NICE (2012 B) states that pharmacists should be sensitive and avoid making assumptions about the individual, such as relying on their personal characteristics or appearance. Thus, the purpose of the attitude questionnaire is to assess the positivity or negativity of the participants' attitudes as well as exploring how these attitudes affect health care services.

Previous research about assessing pharmacists' attitudes has already taken place. Scheerders et al. conducted a series of studies associated with pharmacists' attitudes (Scheerders et al., 2011, Scheerders et al., 2009 and Scheerders et al., 2008). Scheerders et al. (2011) compare non-professional and professional attitudes toward depression in community health care in nine European countries. The survey instrument in this study was not suitable for adaptation, because of the comparative approach. The approach taken here took into account pharmacists' attitudes only. Furthermore, the questionnaire was long, which would have made completion difficult for our participants.

Scheerder et al. (2008) compared the attitudes of pharmacists with current (behavioural) practices in the pharmacy, and barriers to good practice. The authors emphasised a comparison between depression and other organic disorders such as asthma. The questionnaire was not suitable for adaption, however, because it does not cover all aspects of behaviour towards people with depression. Scheerder et al. (2008) focuses on medications to treat depression, but does not highlight any other treatments such as psychotherapy for patients. In contrast, to Scheerder et al (2008), the Royal Australian and

New Zealand College of Psychiatrists (RANZCP) state that the risk of depression can arise from biological disorders or psychological or social events (RANZCP, 2009). This debate might indicate the need for a questionnaire to include different treatments for depression to assess the attitude of pharmacist.

Scheerder et al., (2009) present a twenty-three item survey instrument about attitudes towards depression and anti-depressants, which was suitable for adaptation. The study explores community pharmacists' attitudes toward depression such as attitudes toward nature and treatment approaches for depression; attitudes toward the causes of depression; attitudes toward the pharmacists' role in depression care; and attitudes toward patients with depression. These components provide a clear picture about the attitudes of pharmacists towards depression and people with depression, which was most relevant to my research. However, the item called "*Anti-depressants (ADs) are addictive*" was excluded, because there is no clear evidence to support statements that anti-depressants are addictive. However, a study by Scheerder et al. (2011) reports that a large number of pharmacists believe that anti-depressants are addictive. The item *Children (below 12 years) cannot suffer from severe depression* underwent potential exclusion because the focus of the current research is treatment of adults. However, on second thoughts, it remained because it could show the negative attitude of pharmacists towards certain age groups, such as the elderly.

Negative conceptions based on age can unduly influence pharmacists' service provision, which should be evidence based. Scheerder et al. (2009) reports that 9% of pharmacists think children do not suffer from depression. Although Scheerder et al. do not explain why some pharmacists' think that children cannot suffer from depression. My opinion is that this attitude might arise from many factors such as culture, and is not evidence based. A question about age-related depression helps to provide a clear picture about pharmacists' attitudes.

3.3.5 Patients' Satisfaction with Services Provided

From a personal view, poor service can result in negative consequences for the pharmacy if not appropriately addressed when it occurs. Poor service has serious implications not only for patients but also for professionals and non-medical work in the pharmacy. For example, if the pharmacist does not organise his/her workload effectively, this might affect the time provided for patients. Service provided might be poor due to inappropriate behaviour such as, weak communication skills, poor attitude, and a lack of knowledge. Failure to interact and deliver advice to patients appropriately can affect patient satisfaction. Thus, patient satisfaction is an important part of service evaluation.

A number of patient satisfaction questionnaires were available in the literature and one was adapted to meet the needs of the current research. A study conducted in the UAE (Hasan et al., 2013) aims to assess patient satisfaction with community pharmacy. It covers many items concerning practice in the pharmacy such as, the consultation patients receive, the relationship between the patient and caregiver, accessibility of the service and product availability. However, it comprises largely of technical questions about medicine and self-treatment. Focusing on medication-related problem might be normal as this country (the UAE) as part of the role of traditional pharmacy. Moreover, the questionnaire included questions about non-professionals, and the researcher thinks that they were not relevant to the objectives of the current work.

Another questionnaire excluded took place in the UK. Tinelli et al. (2009) assesses the satisfaction of patients with community pharmacy. Even though the questionnaire covered many services in the pharmacy, a large number of items were associated with technical issues, concerning the mode, side effects, and dose of medications. Moreover, the questionnaire included many items concerning non-professional services, which were not relevant to the objective of my study such as, 'I had to wait too long for my prescription to be completed'. Satisfaction with Pharmacist (SWiP) (Hernandez et al., 2000) was a questionnaire validated in the USA that assesses the satisfaction of patients with community pharmacists. It comprises seven items designed to evaluate the

perceptions of patients about the pharmacist, especially, consultation behaviour, and collaboration with patients concerning medicine, awareness and responsiveness to patient needs and patient confidence in the pharmacist. The questionnaire assesses a uni-dimensional construct (face-to-face consultation with the patient) unlike some other questionnaires, which are multidimensional, and it assesses pharmaceutical services. Hernandez et al. conducted the study for people who have physical diseases but not depression. To make the SWiP more relevant to the current study concerning people with depression, NICE guidelines was involved (NICE, 2009 A) and previous informal interviews with patients who removed from depression to SWiP, so this could make the satisfaction representative of the pharmacists' competency.

The patient satisfaction questionnaire (Hernandez et al., 2000) (Appendix-9 and Appendix-14) which were the same but different colour, satisfaction questionnaire was distributed twice, before and after action planning. The participant pharmacists distributed the Satisfaction Questionnaire (Hernandez et al., 2000) to patients. The patients were not direct research participants, but rather their satisfaction ratings were an indicator of pharmacists' performance. Distributing patient questionnaires twice, before and after implementing pharmacist action plans, can provide information about the degree of improvement in services delivery.

New technology allows the undertaking of questionnaires online for practicality and anonymity. However, in the current study, it was difficult to contact patients because it is difficult to observe when patients would visit the pharmacy and it was difficult to monitor when consultations took place. Therefore, the participants handed out a paper-based questionnaire at the time of consultation. Patient responses were anonymous and held securely without any personal or sensitive information. Patients were able to complete questionnaires in private and without fear of identification.

Questionnaires excluded duplicate replies to facilitate tracking. Each pharmacy had twenty numbered copies of the questionnaire for twenty patients: ten for completion both before and after action planning. Therefore, different patients

would be completing the questionnaire before and after action plan implementation. Patients had the option to return the questionnaire direct to the pharmacist or post it to the university, in a stamped addressed envelope. This maximised the options for the comfort, convenience and privacy of all patients.

3.3.6 Capturing the Consultation ‘simulation’

Simulated Patients

Simulated patients took part in this research. Now, a real and simulated patient are defined, and the researcher will show the advantages and disadvantages of using these types of patients in research:

- Real patients are people who have medical problems and who use medical practices (Collins and Harden, 1998).
- Simulated patients are people with a disease or without any actual condition who act as patients in a consistent way (Collins and Harden, 1998).

Simulated patient (SPs) might also be real patients or people who undergo different levels of training to provide consistent clinical scenarios. Simulated patients should not be distinguishable from real patients by experienced pharmacists or other health care providers. Using simulated patients can examine a great range of skills, including personal information gathering, physical examination and consultation. Simulated patients assess the skills of pharmacists when consulting people with depression (Collins and Harden, 1998). **Table 3.1** gives more information about the advantages and disadvantages of simulated and real patients for research and professional assessment purposes.

The plan is to observe scenarios acted out by a simulated patient in the University of Bradford’s mock pharmacy. Although there are many settings where researchers can observe consultations, The researcher; will compare the

advantages and disadvantages between these different settings and justify the place have chosen for observing the simulation.

Four different settings were considered (see **Table 3.2**):

- University of Bradford's mock pharmacy (Plan A)
- Conducting observation in a real pharmacy with simulated patients (Plan B)
- Conducting observation in a company training centre (Plan C)
- Conducting observation in a real pharmacy with real patients (Plan D)

Table 3.1: Comparison of simulated and real patients

	Real patients	Simulated patients
Advantages	<ul style="list-style-type: none"> • They can express their abnormal symptoms such as depression in detail. • The real patient may not incur much cost, apart from travelling expenses. • They exhibit a great level of acceptability to students and staff. 	<ul style="list-style-type: none"> • The simulated patients trained to respond more consistently in the clinical investigation than the real patients, they can perform multiple investigations and are standardised for use in different settings. • The complexity of the scenario is controlled and it meets the training needs for students. • The performance of student might disturb the real patient more than the simulated patient. • The availability of the simulated patient could be higher. The real patient might find it difficult to attend different settings. • Simulated patient can simulate clinical symptoms if real patients are inappropriate such as counselling a patient with cancer. • Simulated patients might tolerate students under investigation more than real patients.

Disadvantages	<ul style="list-style-type: none"> • The availability of real patients could be limited. • Student might unintentionally embarrass the real patient during the investigation. • A patient might be unwilling to participate because of the greater number of students in the investigation. • The behaviour of the real patient could change due to co-morbidity. • Different patients have different experiences, which will probably provide variance in the results. 	<ul style="list-style-type: none"> • Recruiting and training simulated patient is time consuming. • The cost of the simulated patient might be greater than a real patient. • It is difficult to standardise many physical signs such as heart beats in hypertension
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Table 3.2: Comparison between different approaches used in the research

Approach	Pros	Cons
Plan A: Mock Pharmacy	<ol style="list-style-type: none"> 1. Look at available locations for observations. 2. Mock pharmacy facilitates the consultation and brings technology to the mock pharmacy. This avoids restriction and policies present in the real pharmacy. 3. Saves time of the actor coming to the same location. 4. Quiet and relaxed environment compared to real medical health centres. 5. Suitable for the actor to access the premises in the University 	<ol style="list-style-type: none"> 1. Look at time constraints for pharmacists to attend the mock pharmacy. 2. Environment is not as authentic as in the real pharmacy, such as factors like overcrowding of patients.
Plan B: Real pharmacy, simulated patient	<ol style="list-style-type: none"> 1. Look at available location for observation. 2. Look for authentic environment. 3. Look at saving time of pharmacists. 4. Look at suitability for the pharmacists to attend observation. 	<ol style="list-style-type: none"> 1. Consultation time might not be suitable for the actor. 2. Look at possible busy environment. 3. It is difficult to arrange times slots for different pharmacists, as one pharmacist might not be ready after the previous one.

Plan C: Company training centre	<ol style="list-style-type: none"> 1. Look at available of location for observation. 2. Look at saving time of pharmacists because the plan is to invite pharmacist who work beside the training centre. 3. Look for quiet environment. 	<ol style="list-style-type: none"> 1. Time might not be suitable for the actor. 2. Time may not be necessary suitable for every pharmacist to conduct the observation at the same day. 3. There is no a dispensary area?
Plan D: Real pharmacy, real patient	<ol style="list-style-type: none"> 4. Look for availability of location for observation. 5. Look for authentic environment. 6. Look at saving time of pharmacists by the researcher travelling to a community pharmacy. 7. Look at suitability for the pharmacists to attend observation. 	<ol style="list-style-type: none"> 4. Look at how many people with depression will attend in one day. 5. Look for busy environment. 6. Catching the behaviour of both parties at the dispensing desk and consultation room is difficult because some pharmacies do not have camera in the private area.

Real Pharmacy with Simulated Patients

Conducting observations in a real pharmacy: Observing the 'simulated patient' in the real pharmacy may be more authentic because it is in an everyday practice environment, and it could save the time of pharmacists travelling to the University. However, the practice environment is busy and the participants (or researcher) are open to distraction by the flow of patients in the pharmacy. Furthermore, during observations of the 'simulated patient' in the consultation room, a real patient might need to have a consultation in the same room. This would inconvenience real patients by taking away their opportunity to have a consultation, or even cause patient harm.

Training Centre with a Standardised Patient

Conducting observations in a training centre: If a suitable training centre makes itself available, for example, a pharmacy chain's training room, then this would be a practical option. It is possible to have a number of observations in a single day and the environment would be less stressful for the pharmacists. However, the environment would lack authenticity. Pharmacists would also need to be relieved from their normal duties.

Real pharmacy Observation with Real Patients

Real observation plan: Observing the actual interaction between pharmacists and patients in the natural environment would be ideal in many ways. However, it is hard to predict the number of patients diagnosed with depression who visit a particular pharmacy on a particular day. The presence of the researcher could also affect the response of patients during their initial consultations with pharmacists.

University of Bradford 'Mock pharmacy' with Simulated Patient

Current work plan: Consultations between a simulated patient and different pharmacists conducted at the University of Bradford. Simulation provides a controlled environment for observing and an opportunity for participants to reflect back. The environment is also realistic (see Appendix-10: Photograph). It is more predictable and more controlled compared to a real pharmacy. A mock pharmacy is available to train and assess students studying at the University of Bradford. This environment can provide all the elements associated with professional practice, such as, consultation, non-professional work and prescribing OTC medicines. This pharmacy consists of shelves containing real medicines to allow the students to get involved with the same conditions as in a real pharmacy. There is another private room for consultation to allow the conditions to be confidential during pharmacist-patient communication. In addition, there is also a computer available which saves the medical record information of the patient such as, the name of medicines, dose etc.

Interviews can provide accounts of pharmacists' interactions with patients, but not a direct representation of pharmacists' behaviour. Interviews establish a set of opinions but do not necessarily provide an accurate record of behaviours. Thus, using video enables the researcher to analyse the pharmacists-patients interaction. The researcher planned not to assess skills during the observations so as not to influence the pharmacists. Nonetheless, replaying the videos facilitated the researcher to assess the communication retrospectively and review the consultation repeatedly and this created a permanent record (Asan and Montague, 2014).

In the current study, observing pharmacists' interactions with the simulated patient 'actor' was an important objective. Simulated patients included real patients and actors who have learned to exhibit a health problem (Berger et al., 2005). The simulated patient had a simple and practical background story and needs similar to real patient i.e. a plausible clinical scenario, which enhanced

the validity and monitored the outcome. With patient needs and behaviour simulated, the type of behaviour the pharmacist showed was easier to explore. Conducting the simulated patient in the clinical suit (Appendix-10) at the University of Bradford had advantages for the simulation. Moreover, the mock pharmacy was of the same standard as an actual pharmacy.

3.3.7 Assessing Pharmacists' Skills

Pharmacists should be aware of the psychological, physical and social risk factors for clinical depression especially in the elderly. Pharmacists should have knowledge and competence to screen people who might be at high risk of depression (Canadian Coalition for Seniors' Mental Health, 2006).

The researcher assessed the pharmacist's skills using observed simulation. The researcher assessed the skills of pharmacist based on what they did or did not do (objective) in the consultation, rather than seeking to explain what underpins these skills. The consultation process requires verbal and nonverbal communication skills. Therefore, demonstrating good communication skills during the consultation gained the patients' confidence and helped motivate the patients to adherence to the recommended regimen (Ramesh, 2004).

There are many tools used to assess students or health professionals and to provide feedback for the development of practice and services, and frameworks through which the researcher could assess the skills of the pharmacists.

One of the frameworks is SEGUE, a framework published in 2001. It consists of 32 communication skills that underpin appropriate medical consultation (Makoul, 2001). Based on binary ratings of yes/no for each skill, investigators assess consultations. The scale is for multi-purpose use such as research, teaching and assessment, which makes the tool useful for learning purposes for students and teachers. This framework is suitable for medical students and their teachers. The researcher argues that two essential areas are missing which limit this tool's ability to assess pharmacists' skills. It lacks items to assess the pharmacists' competency for the provision of information to patients. Providing

information related to medicines is an essential skill for competent pharmacists. Therefore, the skills associated with information giving require a clear presence in this tool. Another point is that, this tool does not include the balance between open and closed questions, which is important when eliciting more information and building up the relationship with the patients.

Another tool used in the University but the researcher did not feel is suitable in my research, is the Calgary Cambridge model of communication. It is a tool for consultations in general practice to develop the skills practitioners might not learn at medical school. It is widely used in the UK among medical students, physicians and pharmacists. This tool consists of 71 skills and is a guide for both learning and assessing communication skills. It can be for both formative (for the provision of detailed feedback) and summative assessment (Kurtz and Silverman 1996).

The researcher did not expect to observe all skills during the consultations, because the assessment varies according to the aim of the observation. Calgary Cambridge places emphasis on practice, fitted to the clinical setting of the physician, rather than medication-oriented problems suitable to pharmacist-led consultations. Many of the skills require quite long interactions with the patient for the purpose of physical diagnosis and investigation, and a more private environment suits this scenario. Calgary Cambridge was a good tool to assess the skills of the pharmacist. However, It was not used it in the current study because of the stated reasons, and because there is another tool for pharmacist led consultations.

The Medication Related Consultation Frame Work (MRCF) (Abdel-Tawab et al., 2011) (Appendix-11) is a validated tool. It is for learning and assessing skills used in a medication-related consultation. It provides key criteria explained below for a formative assessment tool, and used to identify pharmacists' strengths and weaknesses when conducting medication-related and client-centred consultations. The tool is for pharmacists who play an increasingly essential role in providing patient-centred approach, such as Medicines Use

Reviews and providing consultations. The tool may also be relevant to other professional groups such as a nurses involved in medication-related consultations.

Assessing the Relevant Tool

The tool comprises five sections:

- (A) Scene setting or Introduction - where the practitioner intends to initiate a relationship and engages the patient;
- (B) Data collection and problem identification - pharmacists obtain relevant information from the patients. Pharmaceutical care needs identified and prioritised. This was an important section that required the pharmacists to identify what medicines patients take, how they use them, and explore concerns of the patients about the treatment;
- (C) Actions and solutions include a discussion on how the problems identified might be solved or prevented and to negotiate shared management strategies;
- (D) Closing section - pharmacists discussed possible plans with the patient, in case something becomes worse, negotiates and agrees a follow-up plan; the final section; and
- (E) Lists consultation behaviours demonstrated throughout the consultation. The assessments of individual activities and behaviours require a binary (yes/no) assessment.

The intention was not to assess the skills of the participants during the consultation in order to reduce the impact on the participant, and to make the environment friendly, rather than testing the participants.

3.3.8 Interview to Encourage Reflection

Interviews took place with each participant (community pharmacist) after observation, but before the interview, the participants had opportunity to see their video. Offering the video helped the participants remember their behaviour

when communicating with the patient. However, it depends on each person if the participant is happy or otherwise or just takes part in the interview. The interview includes the simulated patients, participants and the researcher in the mock pharmacy (stated earlier). The researcher engages the simulated patients to encourage the participants to share the information and to exhibit their preference and values that we would not cover if the discussion takes place between the researcher and the participant. An interview between the researcher and each pharmacist was seen as a specific type of interaction, in which the researcher and each pharmacist produced data about their beliefs, ways of viewing the people with depression and the usual provision of care (Dingwell and Murphy, 2003).

Many methods can capture data in qualitative and quantitative analysis, such as documentation and interview. Investigators might miss documenting some behaviour while observing patients. Some investigators rely on their memory and postpone some of their work and then this leads to loss or the inaccurate recording of data (Mack, 2005). However, in the current research audio recording was suitable to capture the data of the interviews because it is a reliable and reproducible tool. In the current study, interviews with pharmacists and the simulated patient took place to provide feedback. Recording allowed the researcher to dedicate full attention to the participants and provide an accurate, verbatim record of the interview, capturing the language used by participants.

Gibbs Model of Reflection

The researcher prepared to ask predetermined questions through which the information was obtained (based on Gibbs' model of reflection) (Appendix-12). The interviews apply Gibbs' reflective model (Gibbs, 1988) with the pharmacists and patient 'actor'. Gibbs' structure is clear and allows for description of the event, feelings about the event, evaluation of experiences, and analysis to make sense of the experience and examine their practice through action plan. Gibbs encourages the pharmacists to formulate an action to facilitate reflection

and so pharmacists look at their practice and what they would change in the future (learning through repetition). There are other models of reflection, such as John (2002) which provide good explanation and encourage to critical reflection, but there are many questions possibly irrelevant to the intended discussion of our research, such as questions about ethics. The framework is long and it may make discussion uninteresting because there are many questions associated with the feelings of other people that may be an advantage. The structure of the Gibbs model is similar to CPD and the next section will deal with and Gibbs less critical. Using Gibbs with the participants provided a good picture about practices and with the help of a simulated patient, in our study Gibbs is the pre-step before implementing CPD; Gibbs is thorough and provides critical thinking about the learning needs.

3.3.9 Implementing an Action Plan in the Practice

Medications play a vital role in preventing and treating disease. However, evidence shows that patients should make the best of their medications. Non-adherence to medication needs the immediate involvement of pharmacists to support patients, and this develops medicine optimisation for example, reduce patients' concerns and enhance their medication adherence. This is a patient-centred approach that patients involved in decisions about their medications and in a mutual partnership with pharmacists. This approach can support patients to take responsibility for their treatment (Royal Pharmaceutical Society, 2013 A).

The General Pharmaceutical Council (2011) (CPD) (Appendix-13) is a continual process of lifelong learning: skills, knowledge and experience that the pharmacist can gain as they work. It follows a cycle of four stages: reflection, planning, action and evaluation. It is a record of what the pharmacists experience, learn and then apply.

The participants were encouraged in the interview to reflect on their practice, guided by Gibbs model (previous section). The participants were aware of the

CPD because they practice this training in real practice. Participants had the option of undertaking an action plan when they had completed the interview.

The Community Pharmacist has a unique position, in that they are accessible and in direct contact with patients. This position needs pharmacists who are able to deliver best practice to patients. In the beginning of building up current methods, the plan was to engage pharmacists in a short training course to reflect on their practice. However, due to ethical issue (avoid presumption that the pharmacists need training) the plan changed to encourage pharmacists to practice CPD as another method of reflection. It is a framework to ensure pharmacists are competent to provide high quality of service (Waterfield, 2008).

CPD has become a practical activity due to increased knowledge in pharmacy practice. The new role of community pharmacists sways towards clinical emphasis and this makes the profession challenging. The challenge is to ensure pharmacists have skills and competencies in their practice, and this includes pharmaceutical knowledge and the confidence to make decisions in the practice (Waterfield, 2008). According to Waterfield (2008), Continuous Professional Development (CPD) follows a cycle of four stages: reflection, planning, action and evaluation. It is a record of what the pharmacists experience, learn and then apply:

1. Reflection on Practice

Pharmacists can determine their learning needs. Pharmacist's own reflection focuses on what the pharmacist sees are his limitations and needs in their knowledge, skills or experience, and works towards developing or deciding how he would gain such professional abilities to keep up-to-date with what is new in the profession. In the current research, simulation provided good opportunity for participants to reflect on their skills when interacting with patients, they were encouraged to improve skills that were relevant to their practice and give advice and information for safe and effective therapeutic medications.

Although personal reflection is the main mechanism for identifying CPD needs, peer group consultation, or involving a mentor may help achieve these from an

objective view. The peer group may help to make sure that the learning objectives cover a wide range of areas relevant to the pharmacist's clinical, academic and professional developmental needs.

2. Planning

The pharmacist sets a time to achieve the learning needs. At this stage pharmacists prioritise 'urgent and immediate' objective learning needs and make decisions to see if they can meet the needs, such as managing time. The researcher highlighted to the participants the importance of managing the time for CPD rather than making it loose. However, it was necessary to consider time pressures. Pharmacists assessed the importance of each learning need to their practice, organisation and other colleagues in the medical care setting. The pharmacists also decided what resources (time, finances, etc) are available for meeting the learning objectives. The pharmacist could then make a balanced plan for meeting not just short-term urgent needs but also the long-term needs of keeping up-to-date in the field, contributing to knowledge in the field and supporting colleagues and junior pharmacy trainees etc.

Continuous reflection and planning is necessary for professional development as professional development and training needs may change with time as e.g. more medications are introduced to the market and new guidelines are developed or updated. The researcher offered the participants help concerning source of information, for example published papers and any guidelines they would like to read.

3. Action

Pharmacists implement their CPD plan made during the reflection and planning stages. The plan takes place within a defined time and resources and the researcher is in regular contact with these participants to encourage them to act on this plan. An important part of this section is the need for the pharmacist to reflect again on what skills, knowledge and attitude he/she has gained and how effectively they achieved the intended objectives. The action stage may consist of case based discussions, attending conferences, attending topic discussions,

self-reading, etc within house or external training events. It is important that there is a variety of topics as well as topics relevant to the specialty covered and those that could help maintain professional developmental needs.

4. Evaluation

Evaluation is again a continuous process. Here the pharmacists assess their improvements, skills gained etc by rating the extent of learning objectives they have achieved. The pharmacists also need to assess how they could apply the achieved skills for improving the quality of service and effectiveness of clinical interventions. The evaluation may take different forms like note keeping, reflections, feedback from colleagues and feedback from patients, audits, research etc. Obviously, referring back to the needs of the pharmacist is the baseline for any assessment of a training event.

3.3.10 Patients' Satisfaction after Implementing an Action Plan

Satisfaction is the extent to which the patient's needs are met, how helpful, suitable and effective a service is (Chui, 2009). Tipton, states that patients have many satisfaction perspectives and patients assess their perceptions of a service relative to their expectations for that service. The expectation the patient holds for the service becomes the standard. Patients evaluate the discrepancy between their expectations and perceptions of the service. If the patient recognises that the service provided during consultation exceeds their expectations, they will be satisfied with the service. In contrast, if the consultation does not meet their expectations, they will be dissatisfied. The interesting thing is that their expectations may come from their own experience with that particular service, other services like it, and from the experiences of others (Tipton, 2009).

At this step, the purpose of the questionnaire is to evaluate the improvement of the participant (community pharmacist) when providing services after implementing an action plan see (Appendix-14). The questionnaire has similar content to the previous questionnaire (3.3.5), but the time to assess the questionnaire by people with depression occurred after each consultation from

the participant. The researcher expects that when the community participant applied the action plan this may enhance the service provide to people with depression. Consequently, this may enhance patient satisfaction with the service.

3.4 Validity and Reliability

3.4.1 The Quantitative Approach

The quantitative approach refers to the method used for the quantification of the measurement of human behaviour in social sciences research. Overall, the quantitative study of human behaviour encompasses a positivist view, and most behavioural research takes place within this paradigm. Therefore, as Smallbone and Quinton (2004) suggest, the instruments of measurement used for this kind of research must be valid and reliable. However, one of the drawbacks of this kind of study is that it is difficult to categorise social life objectively (Saks and Allsop, 2012).

Pharmacists' knowledge, attitudes and behaviours

Reliability

Using objective and simulated tests to measure human attributes or behaviour raises some research concerns. For example, it is essential that any test used is able to discriminate between individuals at the time the research happens and over time. Therefore, reliability is the extent to which measurements are consistent when performed by different individuals, on different occasions, under different conditions, and with supposedly alternative instruments for measuring the same thing (O'Leary, 2004).

Even though the researcher brings their own beliefs and values to research, the role of the researcher is to gather and analyse data, and, therefore research aims need to be explicit and relevant at different phases of the research.

A researcher should be non-judgmental and express himself or herself as clearly as possible throughout the process of the research (Zohrabi, 2013).

The knowledge questionnaire issued to the participants in this research included questions to assess the awareness of pharmacists (the participants) about the management of depression and to assess attitudes towards people with depression and the services they provide to patients. To assess the skills of the participants, the researcher distributed a checklist for use by the participants when they conducted consultations with patients. Furthermore, the participants gave a satisfaction questionnaire to their patients twice during the study.

Pharmacists had questionnaires relating to knowledge and attitudes sent out to them before they attended observation sessions. The participant pharmacists were able to complete their questionnaires in private, away from the researcher, and this helped them become comfortable with the basis of the research and reassured them they were not under any time pressure to take part. This approach facilitated an objective investigation of the nature of communication between the pharmacist and the patient. As Murphy and Dingwall (2003) argue, observation is a good way of capturing interaction. Before conducting the observation sessions, the researcher put the participants at ease by reassuring them that all information they submitted would remain anonymous and confidential. This helped the researcher build up an initial rapport with the participants and create a friendly atmosphere.

Video recordings enabled the researcher to assess the skills of the participants after the sessions had taken place using a checklist. Murphy and Dingwall (2003) suggest this technique. Video recordings allow the capture of the studied phenomena, which, in this case was participant and patient interactions during consultation. This provided a rich source of information, especially because the researcher was not able to deal directly with sensitive information. It captured interactions accurately and enabled the researcher to revisit consultations when assessing the participants' skills. This helped to create reliable data. Moreover,

if research intends to assess non-verbal cues, then video recording is the best technique to use in order to capture complex phenomena or interactions.

The Setting and Environment for Observing the Consultations

The observation sessions were at a 'mock pharmacy' based at the University of Bradford. Over half of the participants who took part in the research were previous graduates of the University and were familiar with the concept of a mock pharmacy. The participants knew that the mock consultations would be about anti-depressants. The participants were given the opportunity to familiarise themselves with the mock setting of the pharmacy before the patient approached with a prescription. A computer was set up in the mock pharmacy where participants could access the medical and personal information of patients. In this scenario, the researcher played the role of a dispensing assistant; he assisted by opening the door and organising medication.

Validity

Validity is the extent to which the researcher has succeeded in measuring what he or she intended to measure. Validity is often further sub-divided into the categories of 'internal' and 'external' validity. Internal validity refers to when the researcher is confident about the cause and effect relationship demonstrated in the study undertaken, and external validity is the degree to which the results of the study can be generalised to other situations and to other people. Generalisation is more commonly associated with quantitative methods (Bowling, 2014).

In the current research, the emphasis was on the qualitative approach in order to explore the experiences and beliefs of the participants. Therefore, the number of participants (pharmacists) studied was relatively small. Although the findings of qualitative research cannot be generalised statistically, they can be theoretically generalised in that the results should have the capacity to be applicable in other situations. In our research patients were recruited by the

pharmacists according to convenience rather than randomly. Therefore, it is probably more accurate to say that this type of research is characterised by transferability rather than its ability to be generalised.

Patients' Experiences with the Pharmacists

Patients had a patient satisfaction questionnaire (Hernandez et al., 2000), issued twice, both before and after the action plan (more detail later) (Hernandez et al., 2000), and patients were recruited by the pharmacists. Patients had full anonymity and confidentiality in order to avoid the potential for bias when questionnaires were completed.

Reliability

According to Bowling (2009) participants who take part in research may feel anxiety when they are being observed or interviewed. One of the drawbacks of this set of circumstances is that participants may respond in the way they feel the researcher wants them to respond, rather than giving their true opinions or showing their true reactions. This is especially applicable to the volunteer patients who took part in this research, recruited by the participant pharmacists. There was a danger that the pharmacist's presence may have swayed the opinions of the patients, and this is why confidential patient questionnaire was used, the researcher gave patient questionnaires to the participant pharmacists who then distributed them to their volunteer patients, and the patients had the option to complete the questionnaire in privacy and send it back in a sealed return envelope directly to the researcher. Keeping the questionnaires anonymous and confidential helped to alleviate any stress felt by the volunteer patients (Bowling, 2009).

Validity

The patients assessed their experience with the participants by completing a questionnaire. The researcher designed the questionnaire from those used in

other similar studies. It did not target specific patients. Furthermore, informal interviews happened with staff from the charity Mind in order to develop the questionnaire and make slight amendments in order to pursue the specific aims of this research. Additionally, an academic supervisor approved the questionnaire. Patients represented from both genders within the West Yorkshire area. The next section will discuss the reliability and validity of the qualitative data.

3.4.2 The Qualitative Approach

Qualitative methodologies, such as in-depth interview and observation, explore people's lives and experiences, and examine subjective meanings that help to explain the processes of actions and decisions made, rather than seeking to measure or categorise behaviour or attitude. Therefore, in qualitative research, reliability relies on 'trustworthiness'.

Reliability

Qualitative methods are consistent with interpretivist paradigms, in that they aim to record the type of data that will enable the researcher to reflect on subjective meaning and interpretation (O'Leary, 2004).

Semi-Structured Interviews

Semi-structured interviews took place with the participants to try to understand their opinions, perceptions and actions when consulting patients. The semi-structured interviews encouraged the participants to talk freely and share opinions, as noted by Ritchie et al. (2003). Both the participants and the researcher work as pharmacists, and this facilitated a greater understanding of the work of pharmacists and their opinions and concerns. This may make the participants comfortable when participating in this study.

During the interviews, the aim was to encourage the participants to establish their agenda by giving them the opportunity to speak, and by listening to them. This took place in a manner that suited the topic of the research. The qualitative

approach assumes there is no one single reality that can be uncovered (Legard et al., 2003).

A model for reflection for gathering data used Gibbs' model, including using open-ended questions. The interviews began with an introduction and participant agendas explored in a gradual fashion making sure that the topics explored were covered, and high levels of consistency maintained in relation to content (Green and Thurgood, 2004).

Audio Recording

Audio recording facilitated the gathering of data in a natural and non-intrusive way, as recommended by Legard et al. (2003). All the participants agreed to the recording of their interviews before they took part in the study, and this prepared them to be comfortable to talk.

Ritchie et al. (2003) explain that audio recording enhances the reliability of data collection and facilitates the natural collection of detailed information. In the current research, audio recording captured the interviews verbatim, and this enabled the researcher to review the interviews afterwards by replaying the audio recordings.

Observation

The section of the thesis that covers methodology looks at the simulated patient consultations in detail. All the participant pharmacists received information letters before attending the observation sessions, and these letters included details of where the sessions were to take place at the University of Bradford. Many of the participants who took part in the research were previous University of Bradford graduates and, so, were familiar with directions to the University and the surroundings of the University.

Murphy and Dingwall (2003) explain that reliability is concerned with the consistency and reproducibility of data. Therefore, to enhance the reliability of

the data the researcher recorded the consultations before verbatim transcription took place. Video recording enabled the researcher to assess the skills of the participants after the sessions had taken place. Murphy and Dingwall (2003) recommend this technique. During the consultations, the researcher kept busy in the dispensary in order to minimise the participants' awareness of observation. However, all the participants had previous experience of undergoing observation as undergraduates when they undertook Objective structured clinical examination (OSCE) as part of developing their practice.

To maximise the reliability of the data, it was important to keep detailed transcripts. In order to facilitate this process, the researcher recorded and reviewed transcripts to obtain accuracy. Moreover, the transferring of conceptual forms into 'themes and categories' from transcript to N Vivo 10 software (QSR, 2014) was undertaken, so that the data could be easily moved and managed. The use of specialist software helped the researcher analyse the data and the unstructured text collected as part of the mock pharmacy sessions and interviews. This software helped the researcher with indexing and the retrieval function. Using N Vivo, the researcher was able to differentiate between relevant data in order to make a suitable initial analysis of the data, as recommended by (Pope, 2006). As it will be stated later about the analysis of qualitative work involves, a thematic analysis (explained later) was undertaken based on the principles of framework analysis. Undertaking a thematic analysis comprises identifying a thematic framework, indexing, charting, and mapping. Comparing cases within the data allowed the researcher to look for regularities in the data (key themes) and to build typologies. Comparing data within a case enabled the researcher to explore the contextual meaning of the account (Green and Thorogood, 2004; and Ritchie and Spencer, 1994). To enhance reliability, all key stages of the research underwent review and approval by the academic supervisor, and problems resolved if they arose. This happened in order to give the analysis greater weight and consistency.

Reflexivity

The qualitative researcher tends to be less convinced about the feasibility of achieving standardisation and accepts that the social context in which the data is collected has an impact upon the data. Reflexivity when the researcher understands that the nature of their presence contributes to the data collected via interview or observation (Murphy and Dingwell, 2003). The presence of the researcher draws attention to the variability of the data associated with the participants. In the current research, the researcher tried to put the participants at ease before interviews and observations began. However, the nature of research means that the researcher has to extract data from the participants. O'Leary (2004) notes that variables such as age and social status are likely to affect the data collected, especially when the researcher does not take variables, such as these into consideration when planning the research. In the current research, the majority of the participants were in their twenties and thirties. To prevent inconsistencies, we set up simulated patient consultations and the pharmacists recruited to take part were comfortable with the conditions of observation and were motivated to engage in the research. Moreover, the researcher focused on exploring the current practices of the participants and plans for developing their practice.

Validity

Transferability refers to the degree to which the results of qualitative research can be generalised or transferred to other contexts or settings. From a qualitative perspective, transferability is primarily the responsibility of the one doing the generalising. The qualitative researcher can enhance transferability by doing a thorough job of describing the research context and the assumptions that are central to the research. This being the case, researchers and readers can then begin to make connections from the data between local and community-level behaviour and practices (Shenton, 2004). However, summarising data may change the meaning of the data and reduce its credibility (Saks and Allsop, 2012). Audio recording method was used and transcribed verbatim transcripts to avoid substantial summary and re-wording. Furthermore, to enhance the validity and reliability of the research. Multiple

theories were combined to produce more accurate, comprehensive and objective representations. The research used questionnaires (as described earlier), the observation of consultations, and interviews, in order to elicit enough information to facilitate a thorough understanding of the participants' decisions, attitudes and motives (Murphy and Dingwell, 2003).

3.5 Sampling

3.5.1 Qualitative Sample

Certain ethics must guide the researcher when observing and conducting interviews with patients in order to gather rich data. In this study, the researcher selected the sample demographic for specific reasons in order to facilitate the research (Holloway, and Wheeler, 2010). Purposeful targeting helped to recruit participants to study the relationship between the community pharmacist and people with depression who use a pharmacy. This deliberately non-randomised method sample aimed to sample people with specific characteristics.

Community Pharmacists

The researcher recruited participant pharmacists (Appendix-15) to show how they interacted with patients. In real life situations, not all pharmacists offer consultations to patients, but this study provided the opportunity for all pharmacists to be included in a consultation exercise. Sample sizes used in qualitative studies usually comprise between fifteen and fifty people (Smith, 2002). However, because qualitative research requires a detailed and in-depth analysis of data, the sample size in this research reflected the need to reach saturation of the data. Saturation (more details will be explored later) is the point at which no new themes emerge from the data.

3.5.2 Quantitative Sample

Patients Recruited Before the Action Plan

The patient satisfaction questionnaire assessed the patients' satisfaction with the services provided by the participant pharmacists, and, for this reason, not

less than 100 patients took part. Therefore, every participant was required to recruit ten patients to take part, and this was done opportunistically (using convenience sampling) (Bowling, 2014). This facilitated an easier approach, whilst not aiming to generate a random group of respondents.

Patients Recruited After the Action Plan

This step involved inviting patients to complete a questionnaire after they had attended a consultation with the participants. This approach was useful because it was difficult for the researcher to recruit the required number of patients and to implement an action plan. This approach was favoured over a random method of sampling, which is valuable in quantitative studies in order to determine cause and effect. In real life situations, the pharmacy environment is not subject to control, so it is difficult to assess patient satisfaction. However, one of the obstacles faced was sample clustering (i.e. in relation to age, among other variables). The number of patients sampled during this phase was similar to the number sampled before the action plan in order to enable the researcher to compare statistically between the two groups.

3.6 Ethical Considerations

A code of ethics guides researchers and these ethics should include ensuring the safety, anonymity and confidentiality of the participants (Appendix-16; A and B). Researchers must take into account any form of harm that may result from the participant's engagement with the research, especially in relation to participants sharing sensitive information about patients, and patient confidentiality. Participants might appear comfortable and exhibit their willingness to engage during the interview, but may later regret having been so open. Therefore, participants must receive a clear explanation of the purpose of the research and assurances of confidentiality before they take part in a study (Murphy and Dingwall, 2003). To minimise risk participants are required to give informed consent to participate; they knew of the nature and details of the study before starting it via an information letter. The following clauses were included in the letter:

- You may find the role-play experience a little stressful, but we are not really judging your performance.
- We will make a recording, but this will be used only for research purposes and not for teaching or broadcast.
- You may stop at any point for break or if you want to withdraw from the study.
- All responses will be strictly confidential (the personal information is coded). Your personal data and video will be destroyed but not until the study has been completed and any papers published, which may be in about 3 years' time.

The researcher obtained ethical approval for this research from the University of Bradford, Local Research Ethics Committee (Appendix-17) on 11th April 2014 in relation to pharmacist self-assessment of attitude and knowledge, observation of simulated practice and a patient satisfaction survey. During the piloting stage the participants (practitioners and MPharm students) received consent forms (Appendix-18) and participant information letters to enable them to gain a better understanding of the research. The second phase of the study was the consultation observation and interview. NHS ethical approval was not required because the research elements of the study only involved pharmacy staff. Although, these NHS employees provided NHS services, the study took place in their private time and/or on University premises; the participants were not NHS employees. NHS patients completed a satisfaction survey, but the intervention enhanced current practice/help pharmacists meet the recommended standard of care and the survey was thus service evaluation. The satisfaction survey collected no personal or sensitive data. Patients deemed able to have a consultation with their pharmacist had sufficient capacity to complete and return a survey form if they wished to do so.

At the time of conducting the study, no NHS organisation was able to take responsibility for research governance in relation to pharmacy practice research because NHS re-organisation has not commissioned this service locally. The research supervisor and sponsor therefore took responsibility for the design and conduct of the research. The researcher got advice from the Chair of a local

NHS research ethics committee and the NHS organisation responsible for research governance in medical general practice (and the research protocol shares with them). These consultations raised no issues of concern. The information letter (Appendix-19) handed out to the participants stressed the destruction of all the data gathered after the completion of the research. Quotes used in the text of the thesis underwent a process of anonymisation and coding for confidentiality. Finally, the retrieval of the patient satisfaction questionnaires took place via pre-paid post or hand out to the related pharmacists who will send it to the researcher with full anonymity that there are no patients personal information are required.

3.7 Recruitment

The recruitment of participant pharmacists, MPharm Students, and people who had depression happened in three phases as follows:

1- The Piloting Phase

Three practitioners who worked at the University of Bradford and three pharmacy students (who were studying on a 5-year 'sandwich' pathway) took part in the study via email. This demographic helped to gather different experiences to enable the researcher to assess skills of pharmacists close to registration and those in practice for longer experience by means of questionnaire and observation.

2- The Second Phase

The researcher looked to increase the number of pharmacist participants in order to meet the objectives of the study. In order to do this the researcher distributed an advert at a local Centre for Postgraduate Pharmacy Education (CPPE) meetings in Yorkshire, and the researcher visited different pharmacies to meet face-to-face with pharmacists to solicit participation. Another advert was placed with a Locum agency pharmacy supplier and the response was not (initially) as high as expected. Eventually, enough participants agreed to take part to generate enough quality data and to meet the aims of the study. Participants received remuneration for their time (compensation equivalent to

being a locum). It took around three months to collect data from the participants. The duration of time in observation and interview was between one to two hours.

3- The Third Phase

Patients received invitations to fill in satisfaction surveys in connection with the services they received from their pharmacists. The patients who took part did not need to attend the research venue, or attend any interviews and observations. However, the patients taking part before and after the action plan were different. The patients were only required to complete two identical patient satisfaction questionnaires at the beginning and at the end of the research, and it was the responsibility of the pharmacist participants to recruit patients to complete the questionnaires. Patients responded from among those who visited the pharmacies where the participant pharmacists worked, and the pharmacist participants invited patients from the same pharmacies they worked in, in order to be able to track improvements in the skills of the participant pharmacist after implementing an action plan.

3.8 Analysis of Results

3.8.1 Quantitative Results

Statistical Analysis: Three questionnaires and one checklist comprised this part of research. Two questionnaires assessed knowledge and attitude, and one checklist assessed skills. The third questionnaire was the Patient Satisfaction Questionnaire, provided to patients before and after the implementation of the CPD action plan. The original questionnaires were recorded manually by the participants (patient and recruited pharmacists), and then the researcher uploaded this data into Statistical Package for the Social Sciences (SPSS). However, because the questionnaires and interview sessions also included qualitative data collection, the statistical analyses of knowledge, attitude, and skills were very basic (that is, descriptive totals and prevalence only).

The Knowledge Questionnaire

This was scored using a Yes/No style system; 1 = Yes (the answer is correct), 2 = No (the answer is wrong), and 3 = Partial (part of the answer is correct).

This questionnaire used percentages for assessment, and questions had three options (correct, wrong, and partially correct), then the highest or the lowest score built the discussion.

The Attitude Questionnaire

The aim of this questionnaire was to assess the attitudes of the community pharmacists towards the treatment of depression, the causes of depression, and the extended role of the pharmacist. The questionnaire comprised four parts, scored using a five point Likert scale. 1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, and 5 = strongly agree. The scale was clustered to include disagree, undecided and agree, so that the researcher could be satisfied with the score to assess the attitudes of the pharmacists. The results of the questionnaire are in basic percentages and then mean percentage scores were calculated.

The Skills Check List

Part of the checklist for skills was scored as follows: 1 = Yes; 2 = No; 3 = Not applicable. However, the checklist comprised five sections and each section contained different items; scores relating to these items scored as 'yes' 'not applicable' and 'no', and other sections scored using 'fully' 'partially' or 'not achieved'. The final reflexive assessment of the entire consultation scored using the Likert scale: 'poor', 'borderline', 'satisfactory', 'good', and 'very good'.

The patient satisfaction questionnaire (before and after) the action plan

The patient satisfaction questionnaire also used the Likert five points scale: 0 = not at all, 1 = a little bit, 2 = somewhat, 3 = quite a bit, 4 = very much.

When the researcher analysed the findings, the scores were clustered into three categories (agree, neither agree or disagree, and disagree) to facilitate

practicality when presenting the results. The results compared as the highest and the lowest percentages of each item (service), and overall satisfaction questionnaire results were not normally distributed. However, the ratings for each item were ordinal in nature, and, therefore, the Mann-Whitney test was a suitable means of analysis. The analysis of the questionnaire results included frequency and groupings both before and after the implementation of the action plans, and this took place to establish any differences in median ratings. Statistically, a larger number of patients would provide for richer data collection and better outcomes, and so it assumed that 100 patients would be adequate for the purposes of the research. An increase of 10% in the proportion of patients who became satisfied demonstrated as a difference of 0.5 - of which 5 in 100 represented a significant difference (Greasley, 2007).

3.8.2 Qualitative Results

Framework Analysis

This particular approach (developed with rapid health policy analysis in mind) assumes that the researcher may hold predetermined ideas or have priori concerns. First, the framework approach is suited to analysing cross-sectional descriptive data, which enables the capture of different aspects of the phenomena under investigation. It includes interconnected stages in the framework approach that explicitly describe the processes that guide the systematic analysis of data from initial management through to the development of descriptive to explanatory accounts (Ritchie and Lewis, 2003).

The management of 'raw' data collected using qualitative methods takes place in different ways, depending on the method used for data collection, for example, observation notes, video, audio recordings, or verbatim transcripts. These methods allow for rich data collection but do not necessarily provide clear meaning or sense, unless the data is analysed and managed in an appropriate way (Ritchie et al., 2003).

The steps in Framework analysis are:

Identifying Initial Themes:

Using the 'Framework' approach, management of data involves deciding how the data undergoes labelling, sorting and comparison under each theme (Ritchie and Spencer, 1994). The researcher should immerse themselves in the data and become completely familiar with the data set. During the familiarisation process, notes recorded in the margin of the transcript indicate any recurring ideas or themes (Ritchie et al., 2003). In our study, the researcher searched for themes linked to the objectives of the study, and, specifically, relating to the attitudes, knowledge and skills of the participant pharmacists. However, searching for emerging themes according to pre-determined ideas is not the only or main objective of the research; it is more important to see how new ideas emerge. This means it is necessary to apply a deductive and inductive approach. Recurring ideas gained from familiarisation undergo grouping and sifting into main and sub-groups of similar ideas or themes, and then grouping again in categories or themes ('indexing'). These themes undergo the assignment to text and the core of each theme identifies according to categories that underlie each theme. Transferring conceptual form 'themes and categories' from the transcripts to NVivo10 software (QSR international) can then take place to facilitate easy data management.

Indexing:

After developing an initial conceptual framework, the next phase was to re-read transcripts line by line to gain a better understanding of the data. In order to do this, labelled text undergoes examination to check the fit into suitable categories. This stage is indexing and helps refine categories. When data overlaps into different themes, this implies an interconnection between themes and issues. This is possibly, when a pharmacist consults people with depression, different attitudes, experiences and other factors have an impact on the decisions made by the pharmacists

Charting:

Summarising the data was the final stage. This stage helped to make the data more manageable, and it provided a clearer picture of the essence of the evidence for later representation. Moreover, it encouraged the researcher to thoroughly re-read the transcript for later representation as advised by Ritchie et al. (2003). The researcher decided that key terms, expressions and sentences should undergo retention from the participants' own vernacular language style and that pursuing interpretations should not happen at this stage. At this stage, material could not undergo deletion for irrelevance, because some data is worth keeping for the later stages of analysis. The previous exercise of indexing facilitated the construction of a set of themes for charting, and the number of charts dictates the number of themes. Each main theme and sub-theme 'group' undergoes plotting onto a separate chart. Two types of chart can be used to present information: the case chart and the thematic chart. The researcher chose to use thematic charts because they were more versatile for comparison purposes to detect differences between elements in each theme.

Mapping:

The next step was to refine the categories and define dimensions. This involves looking across each theme to assess the range of experience, beliefs and values of the participants. This undergoes searching for consensus, and if no consensus emerges then it is possible to identify elements of difference in order to 'discriminate' in the typology. The power of typology lies in its ability to locate all cases demonstrating a series of related but independent categories. Following typology, the researcher was able to detect patterns, associations, clusters and sets of phenomena. Linkages and associations in the data created different patterns, for example, causes and effects. The different experiences of the participants led to specific results or outcomes.

Associations between patterns emerge that assist a deep understating of the investigation. During the course of the study, the researcher expected to find matched sets of linkages, and these linkages sometimes crossed different categories, for example in 'skills of the pharmacist' proactive and passive

behaviours were noted, and these behaviours related to both the attitude of the participants and their engagement with patients. Furthermore, sub-group features disclosed patterns of association, for example, socio-demographic factors linked to experiences in practice. The researcher reviewed cases that fitted into a pattern and cases that did not, and this isolated the uniqueness of each case, as explained by Ritchie et al. (2003).

The next chapter will describe the practice of the pharmacists with people with depression.

Chapter 4 Current Practices of the Pharmacists and the Patients' Experiences

For the purposes of clarity, the pharmacists and MPharm students who took part in this research are 'participants'. This to avoid confusion as the term 'pharmacist/s' is used for pharmacists in general (in previous research and in the literature review). The term "pharmacist(s)" refers to members of the pharmacy profession in general and relates to information from evidence based literature, books and health care guidelines.

This chapter includes the pilot and main study. In the pilot stage, the participants did not complete patient satisfaction questionnaire for CPD except for one of the participants in the pilot who completed CPD. The researcher will illustrate the current work of the participants by analysing quantitative results through questionnaires and checklists. This data expresses numerically and in narrative style. Moreover, qualitative results are expressed as narrative

Brief overview of the structure of the results

The findings in this chapter are competencies demonstrated by the pharmacists who took part in this research. These competencies include participants' knowledge about anti-depressants, basic attitudes of participants shown towards people with depression, and the skills demonstrated through observation. The participants went through an initial assessment (questionnaires, patients' satisfaction questionnaire and skills checklist) and then learning activities (continuing professional development (CPD)). A reassessment was undertaken after they had taken part in a short training through patients' satisfaction as indicator for improvement.

The structure of this chapter is as follows:

1. The participants' knowledge about anti-depressants;
2. The basic attitudes of the participants;
3. The satisfaction levels and experiences of the patients at baseline;
4. The skills demonstrated by the participants from observation;
5. The motivation of participants to reflect in their practice;
6. The reflection of the participants on current practice (CPD);
7. Patients' satisfaction with participants;
8. A comparison of patients experiences with the participants.

4.1 The Participants' Knowledge about Anti-depressants

This section illustrates the knowledge of the participants when managing people with depression. Before the results were described, the demographic factors of the participants will be shown as detailed in **Table 4.1** below. The total number of participants was 22; eighteen participants (82%) were males, while the remaining four participants representing (18%) were females. Nineteen participants were pharmacists and three were MPharm students. Their ages were 18-50 Yrs. The majority were in the age range of between 18-30 yrs., a third between 31-40 yrs., and one participant was aged between 40-50 yrs.

Table 4.1: Summary of Demographics of the Participants

Demographics		Number of Participants (22)
➤ Gender	Male	18
	Female	4
➤ Age(years)	18-30	14
	31-40	7
	41-50	1
➤ Experience		
Participants Pharmacists		
Months	Less than one year	2
Years	1-10	13
	11-20	4
MPharm Students	1 year's experience	3

4.1.1 Participants' Awareness Level of Managing People with Depression

The responses to key questions asked are below in **Table 4.2**. The responses list according to the number of participants who were able to answer questions correctly. The percentages presented throughout this study underwent rounding to the nearest percentage point. There were four questions in total: to which all participants answered either correctly or partially correctly, relating to: indication

of anti-depressants, duration of the medications, safety and recommendation of the medications. **Table 4.2** represents the results of the awareness of the participants of depression and anti-depressants. Some questions included only one option for answer, either right or wrong answer, for example question 2, 4, 5, 6, 7, 9, 10, and 12. Other questions may include more than one option of answers for example 1, 3, 8, 11 and 13 and they may carry as (right, wrong or partially correct). The questionnaire results have undergone aggregation because the number of the sample is small and it may not provide any significant difference. Moreover, it is similar to the form of the original adapted questionnaire.

The results show that the participants have good knowledge about managing depression. Almost all of the participants indicated an awareness of the different types of anti-depressant, and how they work and drug indications (95%, 100% and 86% respectively). Approximately two thirds of the participants said they were aware of the duration of time people must take anti-depressants in order to achieve a full therapeutic effect. Almost the same percentage said they were able to make decisions about the effectiveness of older type anti-depressants in comparison with newer medications for depression. However, less than third of the participants (Q.6) did not answer the question satisfactorily, and did not know if newer medications have fewer side effects compared with older medications. Over one third of participants did not answer Q.7 correctly; they said that the harmful side effects of newer anti-depressants were the same or similar to those of older anti-depressants.

It was a surprise to see that more than two thirds of the participants were partially correct when questioned about the nature of the side effects (Q.8) of both newer older anti-depressants: around 10% said that anti-depressants have no effect on a patient's ability to drive, and over one third said that anti-depressants are addictive. A minority of participants thought that there is a link between suicide and SSRIs, and a similar number were undecided on this issue.

Table 4.2: Awareness of the management of anti-depressant drugs

Questions	Correct	Partially correct	Incorrect
1. State the names of three classes of anti-depressant medication.	21 (95%)	1(5%)	0
2. What is the mechanism of actions for SSRI medication to treat depression?	22(100%)	0	0
3. State three clinical indications for SSRI medication	19(86%)	3(14%)	0
4. After starting SSRI medication, how soon will a typical patient experience the full therapeutic effect?	13(59%)	0	9(41%)
5. Are newer classes of anti-depressant medication (e.g. SSRIs) more or less effective than older classes (e.g. TCAs)?	14(64%)	0	8(36)
6. Do newer classes of anti-depressant medication (e.g. SSRIs) have fewer side effects than older classes (e.g. TCAs)?	17(77%)	0	5(23%)
7. Do newer classes of anti-depressants medication (e.g. SSRIs) have less harmful side effects than older classes (e.g. TCAs)?	14(64)	0	8(36%)
8. Many side effects are common to both SSRIs and TCAs. Please mark (X) in the appropriate column(s) to show which medication causes which side effect(s).	5 (23%)	17(77%)	0
9. Do anti-depressant medications affect the patient's ability to drive or operate machinery?	20(91%)	0	2(9%)
10. Can patients become addicted to anti-depressant medication?	14(64%)	0	8(36%)
11. Can SSRI anti-depressants, promote suicidal feelings? If 'Yes', then when?	20(90%)	1(5)	1(5%)
12. For a typical patient, how long is a course of anti-depressant medication?	14(64%)	0	14(36%)
13. What other forms of treatment are recommended by NICE for depression?	22(100%)	0	0
Mean	75%	8%	17%

Furthermore, over one third of the participants did not answer correctly when asked about the average duration of time people must take anti-depressants as a course of treatment, but all of the participants were aware of the guidelines issued by NICE for depression. The greatest percentage of those who answered correctly focused on the use, indications and recommendations for treatment. However, one third of the participants were not aware of safety issues surrounding the use of anti-depressant medications, and one third of participants were not aware of the average duration of time people must take anti-depressants. These results might be because the physician usually makes these decisions.

Some questions were not be answered correctly by all the participants on certain subjects, such as the safety of anti-depressants and the duration of a course of treatment using anti-depressants, knowledge level of the participants was relatively acceptable; a mean of 75% of participants gave correct answers.

4.2 The Basic Attitudes of the Participants

The questionnaire (see Section 3.3.4) aimed to explain the data about the attitude of the participants when intended to offer consultation to people with depression. The questionnaire clustered into three scales: Disagree (meaning positive feelings) undecided (neutral) and agree (negative feelings). There were 22 participants scoring in this questionnaire and it is divided into four domains, the description of each domain will be described and at the end of the four domains with a narrative explanation linking these domains together.

4.2.1 Attitudes towards the Nature and Treatment Approach for Depression

This section represents (treatment approach) (Domain 1). The majority of the participants expressed a positive attitude towards the nature and treatment of depression, see detailed **Figure 4.1** represents the mean score of perception of participants in this domain.

Most participants took the treatment of depression seriously and only a third demonstrated a less serious attitude towards depression. Most acknowledged that it was a real disease, and that children can suffer from depression. Most participants disagreed with the idea that those suffering from depression should be able to 'pull themselves together'. Some perceived depression to be something that is under a patient's control that is relieved without engagement with treatments. This attitude usually accompanied negative attitudes towards using professional options, the idea that anti-depressants were addictive; beliefs that patients with depression can get better without treatment; and the idea that it was possible to treat depression without professional intervention, i.e. it was better to use the support of relatives etc. The results illustrated that participants perceived depression is real disease, and the patient need support, but social support is more effective than anti-depressants which is harmful to the body.

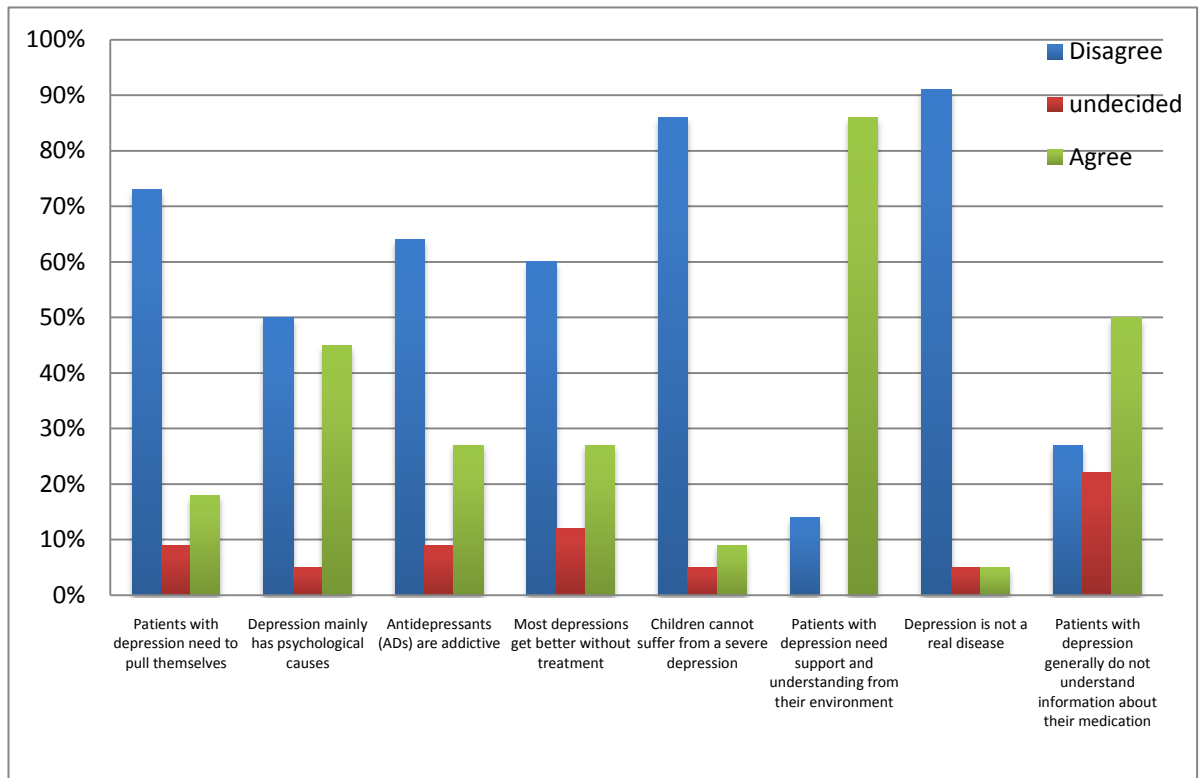


Figure 4.1: Details of attitude of the participants attitudes towards the nature and treatment of depression ‘serious versus non serious’.

4.2.2 Attitudes toward the Inevitable Course of Depression

This section represents Domain 2. In **Figure 4.2** (inevitable vs. malleable), over half of the participants showed a positive attitude towards the prognosis and the ‘malleable’ causes of depression, while around third showed a negative attitude towards treatment approaches and believed there were ‘inevitable’ causes of depression. Regarding the mechanical characteristics of depression, and whether or not depression has biochemical causes the number of participants who supported this idea and those who disagreed were equal. A third of the sample was undecided about this issue. Just less than a third showed pessimism about being able to achieve the complete cure of depression, and a quarter of the sample could not decide on whether it is possible that depression can be completely cured. Moreover, a quarter of the participants favoured using anti-depressants to treat depression.

About half of the sample rejected the idea that complaints about depression were 'normal' in old age. However, a third of the sample believed that complaints about depression were a 'normal' part of old age.

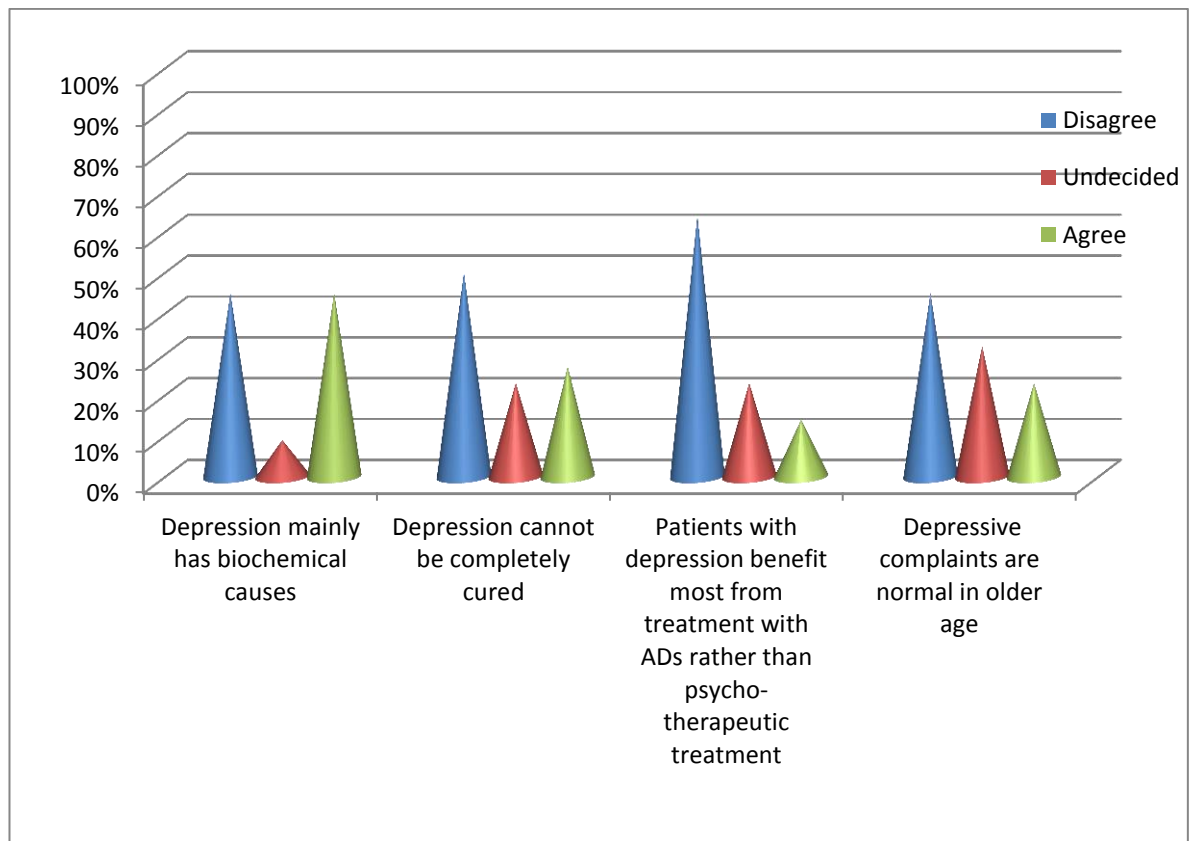


Figure 4.2: Details of attitudes of the participants towards the causes of depression

4.2.3 Attitudes towards Additional Role in Depression Care

This section represents Domian 3. **Figure 4.3** represents details of the attitudes of the participants about providing additional services for patients with depression. Overall, the participants held negative attitudes which associated with the pharmacist's role in depression care. Half the participants said it was important to provide additional services, whilst a third felt that providing additional services was not necessary and quarter who undecided. Over two thirds of the sample believed that patients with depression do not receive all the necessary information they need about this disease, both from general

practitioners and psychiatrists, and this perception was exhibited by half of participants who agreed that patients less interested to talk with them. The participants did not give the disease more attention and half of them believed that depression was a disease just like any other disease.

Over two thirds of participants felt that physicians do not provide enough information about antidepressants to patients and quarter were undecided about this. It is surprising to note that the comparable number of participants did not decide if patients adhere to the recommendation or no, and less a third of the participants undecided if patients followed the instructions they received about antidepressants.

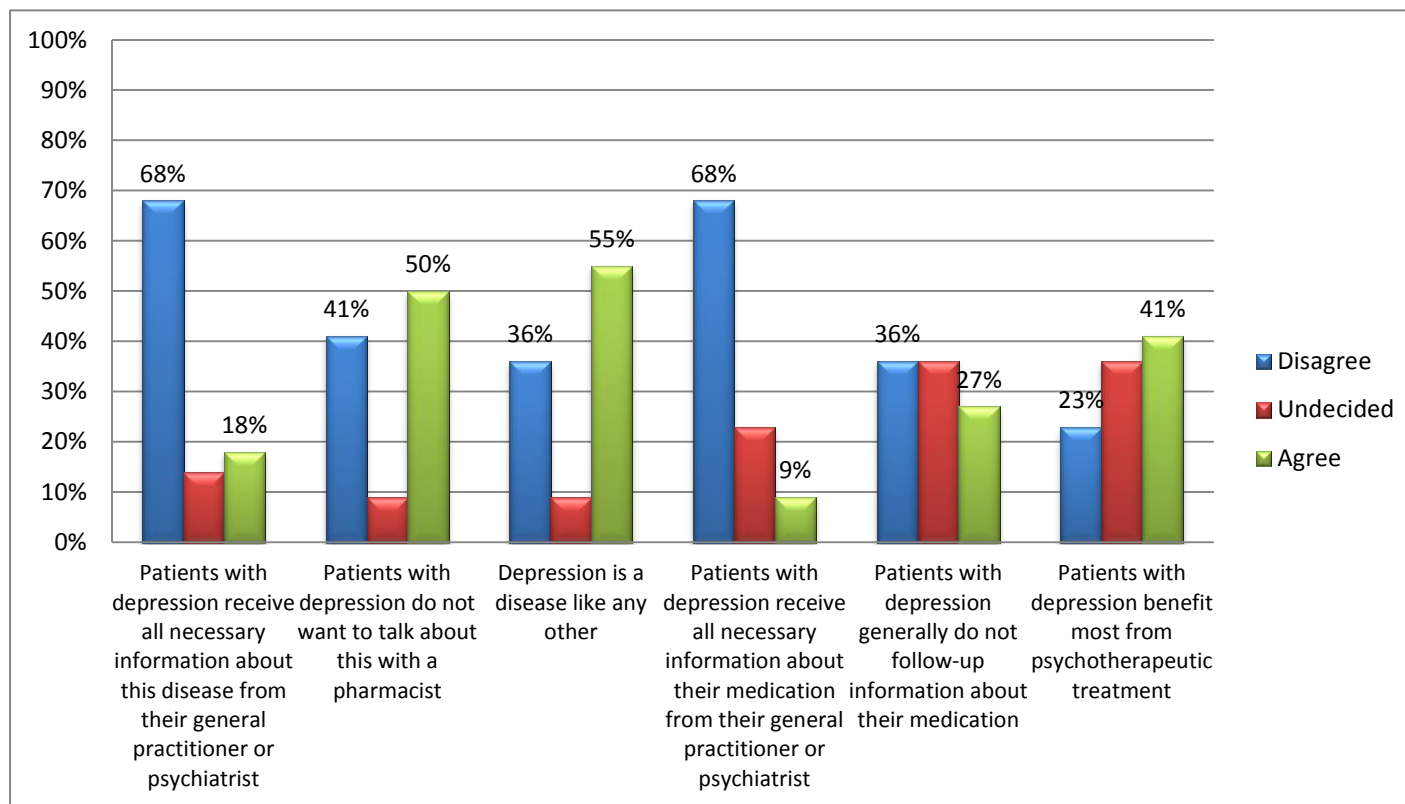


Figure 4.3: Details of attitudes of the participants towards providing additional service for people with depression

4.2.4 Attitudes towards People with Depression

This section represents Domain 4. **Figure 4.4** shows how most participants had positive attitude toward people with depression. However, 32 % and 27% agreed and undecided respectively than anti-depressants can change one's personality. The majority of participants rejected the argument that patients with depression put a strain on pharmacist services, for example, by making persistent enquiries about certain medications, the participants found that patients with depression did not place excessive demands on a pharmacist's time. The majority of participants found that it is possible to rely on patients with depression. However, the majority agreed that social event is the main cause of depression, while they were less giving genetics and other risk factors more attentions. The majority of the participants said that weakness of character was not the main cause of depression.

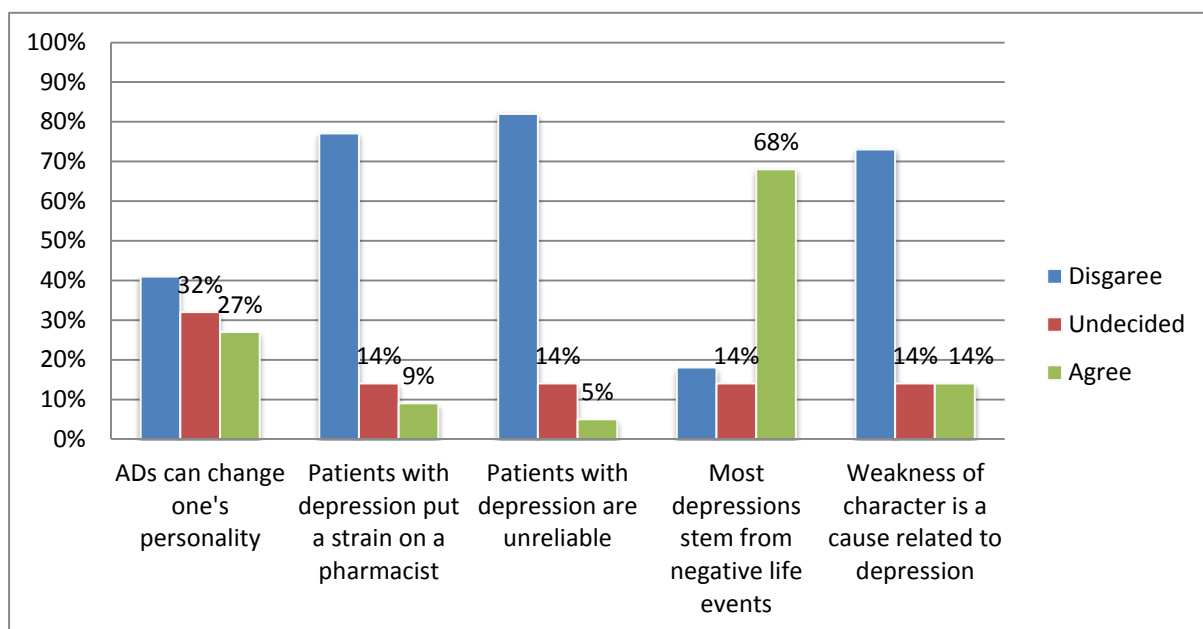


Figure 4.4: Details of attitudes of the participants towards people with depression.

4.2.5 The Relationship between the four Domains

Overall, **Figure 4.5** shows that the participants held compassionate attitudes towards the nature of depression, its treatment, and people with depression. The lowest percentages were recorded when participants were asked to consider their role in providing additional services.

The participants named various possible causes for depression. They said that the causes of depression are social problems or biochemical or psychological disturbances, but they perceived social problems as the most likely cause of depression. The participants felt that anti-depressants do not represent the best possible treatment option, but perceived that when patients take anti-depressants they do experience benefits. Moreover, although the participants valued the efficacy of anti-depressants, they expressed reservations about their safety that more than third of the participants agreed that anti-depressants can change one personality (Domain 4).

The results reveal that health care professionals appear to place a significant amount of professional distance between themselves and patients, the participants said that physicians sometimes do not provide satisfactory information, but, generally, the participants take no action about this (Domain 3). This evidence may link to Domain 1 where half the participants stated that patients do not understand the information they are given about their anti-depressants. Moreover, (in Domain 4), one third of participants were both undecided and had negative feeling about the impact anti-depressant on the patient's personality. They said that anti-depressants are not as effective as other more social based treatments (Domain 3) and double the number of participants who favoured social treatment than anti-depressants. The scores for can be contrasted to those of Domain 4 where the participants scored highly in terms of their positive attitude towards patients, but less positively in their skills for managing patients (Domain 3).

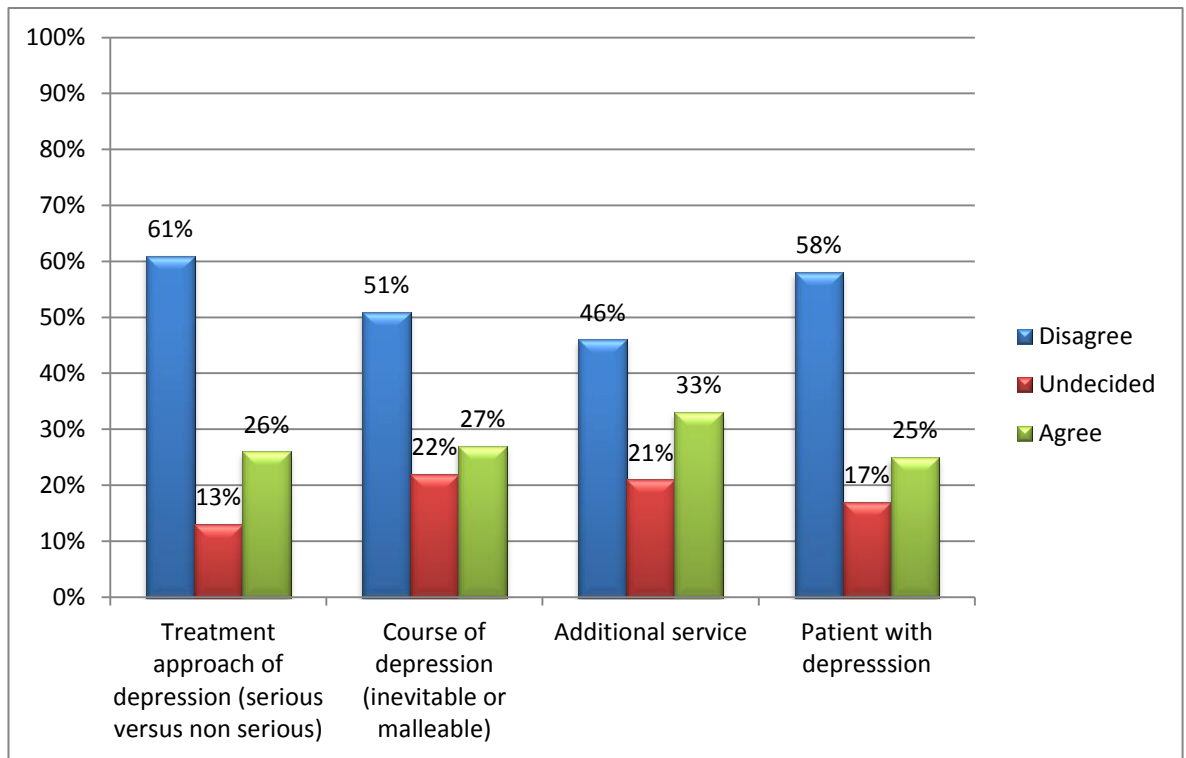


Figure 4.5: Summary of the results of the four 'attitude' sections.

4.3 The Satisfaction Levels and Experiences of the Patients at Baseline

The number of patients was 160 who indicated they were happy to take part in this stage of the research. **Table 4.3** below shows the demographics of the patients who took part. The patients who took part in this stage of the research (before the action plan) were not the same patients as those who took part after the action plan (mentioned in the method of recruitment earlier). However, the patient demographics of the two groups share similar characteristics, and the patients surveyed came from the same area of West Yorkshire. Furthermore, all patients surveyed had diagnosed depression and were taking anti-depressants as part of their prescribed treatment. Nevertheless, one of the limitations of the study is the difficulties posed in trying to recruit the same patients. Different patients came in for the different stages of research mainly because of limited access to patients who visited the same pharmacy. The majority of the patients surveyed were aged between 20 and 29 years, and the fewest patients who took part were elderly. However, the number of females who took part was double that of males, and white patients represented two thirds of the patient demographic. This section will outline the results of the patient satisfaction questionnaires. See Section 3.3.5 for more details about methods of choice.

Table 4.3: Patients' demographic factors (before action plan) n=160

Age	Number- Percent	Gender	Number- Percent	Ethnicity	Number- Percent
20-29	30 (19%)	Male	54 (34%)	White	102 (64%)
30-39	38 (24%)	Female	106 (66%)	Asian	40 (25%)
40-49	50 (31%)			Black	11 (7%)
50-59	29 (18%)			Mixed	6 (4%)
60-69	10 (6%)			Other	1 (0.6%)
Over 60	3(2%)				
	100	Total	160	Total	100

4.3.1 The Experiences of Patients with the Services Provided

Table 4.4 shows that patients who took part in this survey did not report high levels of satisfaction when interacting with the participants. A high percentage of patients did not feel that the participants offered them privacy for consultation, and only half of the patients reported that the participants gave them instructions about the administration of medications. Patients demonstrated a lack of confidence in the participants' knowledge. A quarter of patients did not feel that the participants dedicated enough time to offering services, and one third said that patients did not decide the right amount of time, this agrees with the low scoring by patients for talking about patients' progress with treatment. Less than a third of patients agreed that the participants managed medication from GPs well but less than half of the patients agreed that participants were aware of their treatment related needs.

Patients rated the participants low for explaining side effects; this links to (Section 4.1.1) the evidence showing that the participants did not answer questions about the side effects of anti-depressants satisfactorily. Furthermore, the participants were less willing to follow up patient progress, this may link to (Section 4.2.3; Domain 3) that participants less provide additional service to patients.

Overall, patients were not satisfied with the kind of interaction they had with the participants. The majority of the scores were fifty percent or less.

Table 4.4: Patient satisfaction before implementing the action plan

Your opinions	Agrees	Neither agrees/neither disagrees	Disagrees
1. My pharmacist offers to talk to me in private	55(34%)	38(24%)	67(42%)
2. My pharmacist advises me on the proper use of my medicines.	81(51%)	39(24%)	40(25%)
3. My pharmacist advises me on the adverse side effects of my medicines.	70(44%)	43(27%)	46(29%)
4. I have confidence in my pharmacist's knowledge about depression and its treatment.	66(41%)	45(28%)	50(31%)
5. I have confidence in my pharmacist.	99(62%)	22(14%)	39(24%)
6. My pharmacist is available to answer my questions.	85(53%)	50(31%)	26(16%)
7. My pharmacist is willing to talk to me about my symptoms of depression and progress with treatment.	58(36%)	43(27%)	59(37%)
8. My pharmacist helps with the arrangements necessary to obtain my medicines.	91(57%)	43(27%)	26(16%)
9. My pharmacist is aware of my treatment-related needs.	72(45%)	45(28%)	43(27%)
10. My pharmacist responds to my treatment-related needs.	78(49%)	40(25%)	42(26%)
11. I would recommend my pharmacist to other people with depression.	89(56%)	30(18%)	41(26%)

4.4 The Skills Demonstrated by the Participants from Observation

This section will present the results from participants during the observed consultation (Section 3.3.8). There are 22 participants observed. The checklist is divided into five divisions and each division includes statements by which researcher can assess the skills of the participants. The score in this checklist includes Yes; when the skill is performed and No when the skill is not performed; and not applicable if the performance not relevant to current observation condition.

4.4.1 Initiating the Consultation (Skills Section 1)

This part of the research aimed to examine the participants' skills and behaviours in establishing therapeutic relationships with patients. The participants in **Figure 4.6** demonstrated poor initial rapport with the patients; the mean (28%) demonstrated competence in this section. The majority of participants did not perceive that was necessary to make introductions to patients. Higher scoring participants invited the patient into a private consultation area, but the majority did not outline the purpose and the structure of the consultation to enhance patients' expectations. The minority of participants were able to negotiate the agenda and encourage patients to be engaged in mutual discussion. It appeared that the participants were less interested to build initial relationships with patients to make patients comfortable and to raise their concerns. This possibly guides us to the next section about whether or not the participants able to elicit information from patients for expanded discussion.

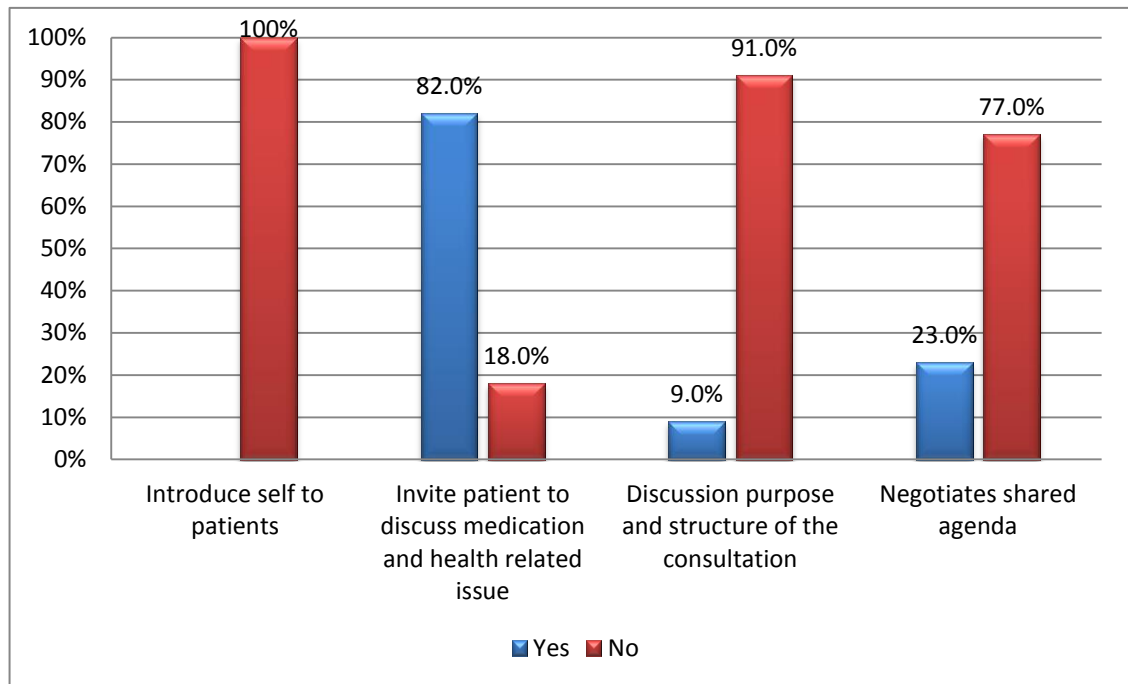


Figure 4.6: Initiating consultation sessions

4.4.2 Data Collection and Problem Identification (Skills Section 2)

The majority of the participants (**Figure 4.7**) were successful in gathering medication information from patients. However, many did not try to gather information from patients about their social history. Some condition skills were not applicable because we assessed newly prescribed patients. Over two thirds of participants satisfactorily asked patient about the reason for prescribed medications in order to encourage patients to understand their illness and enhance their knowledge of the medication, while around two third of the participants who were able to discuss with the patient about the trigger cause of depression, who may think it is not their role. It is obvious from the data that just the minority of participants who identifies if patients had pharmaceutical problems. It appeared that the participants were less enthusiastic to elicit information about social information and less able to elicit information about the condition who thought it is not their role to, while they were more willing to receive information about the prescribed medications; but not the past medications.

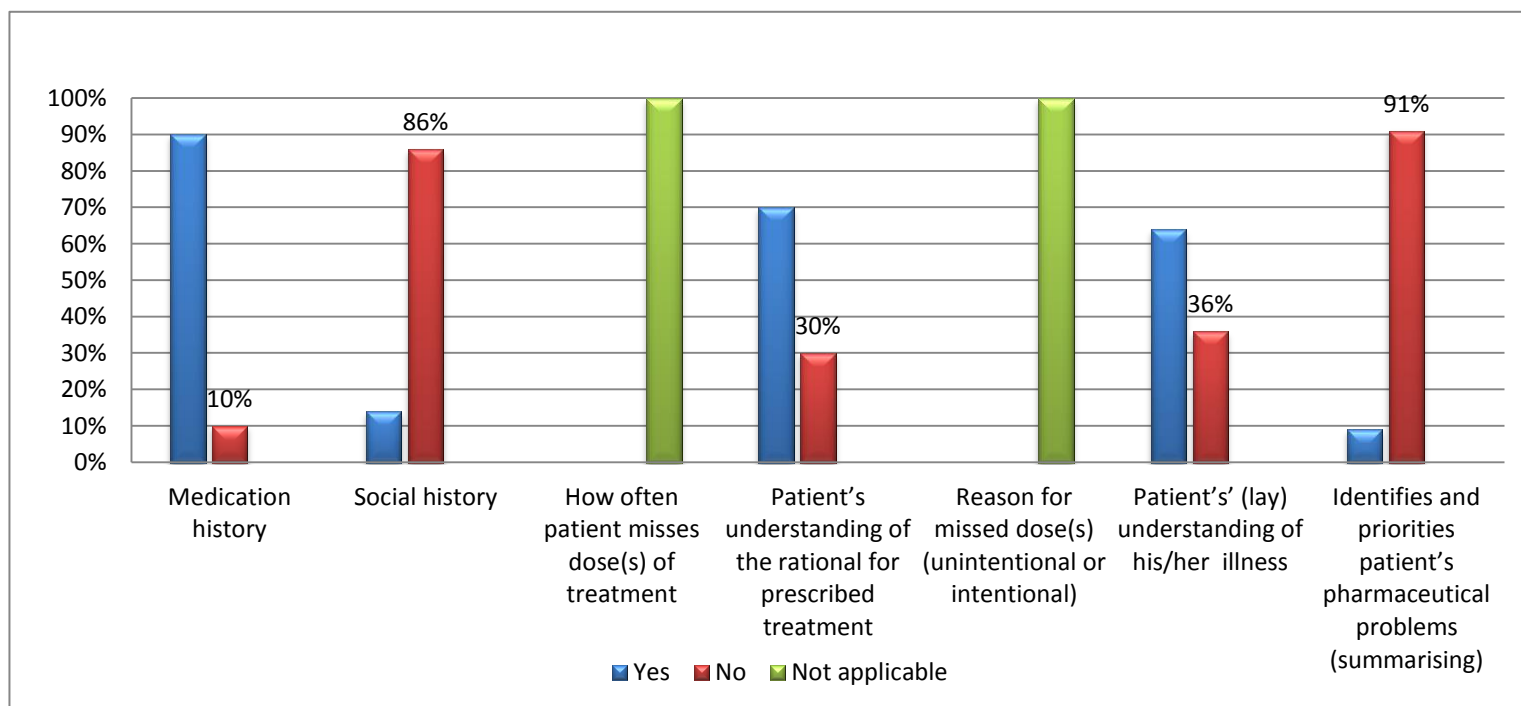


Figure 4.7: Data collection and problem identification

4.4.3 Actions and Solutions (Skills Section 3)

Few of participants demonstrated adequate skills in this section, see **Figure 4.8**. There was a tendency for the participants to explain medication to patients without checking the patient's ability to understand or follow through with the plan. The participants gave advice to patients not tailored to the patients' risks and benefits. It is inapplicable to assess the participants for involving patients in designing a plan as this possibly the decision of the physicians. Moreover, the participants tended to check the patients' understanding of things said by simply by asking at the end of the discussion. Furthermore, the majority of the participants used closed questions to assess patient understanding. The participants in this research were competitive when giving technical advice about anti-depressants, including aspects relating to efficacy and safety, and this implied that the participants perceived this role as important when advising about medication.

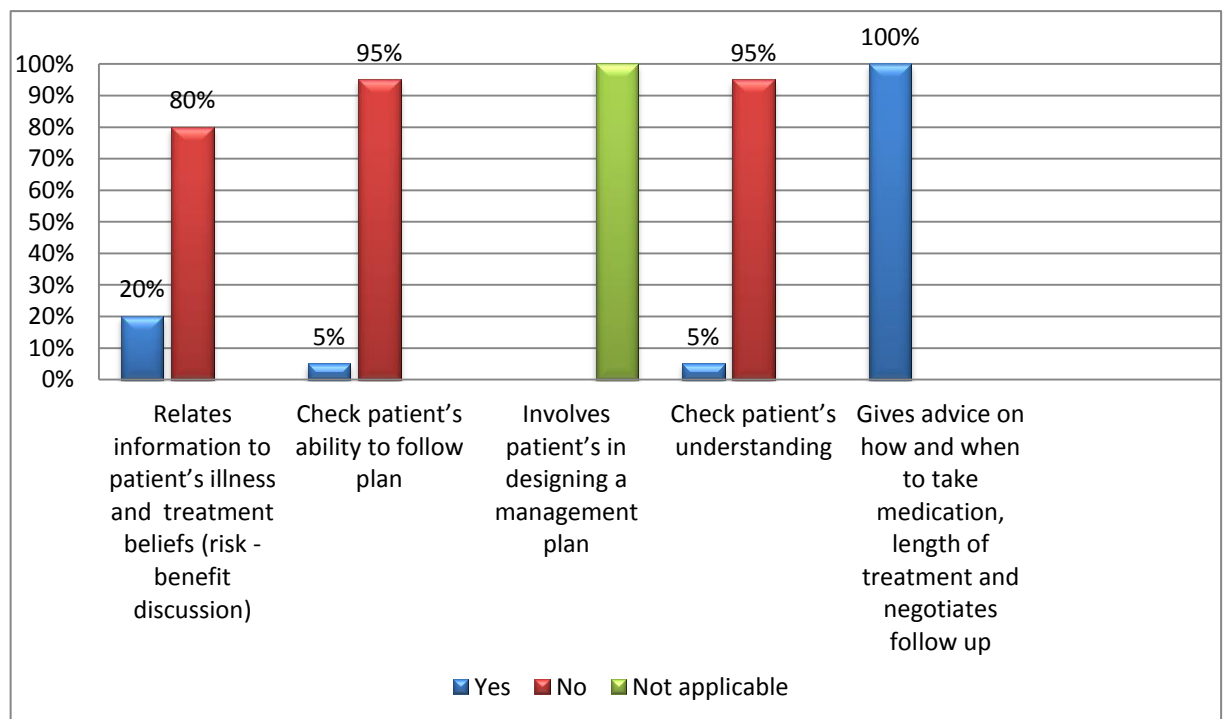


Figure 4.8: Skills demonstrated for actions and solutions

4.4.4 Closing the Consultation (Skills Section 4)

The participants had good skills to ensure that patients were signposted towards proper health support (**Figure 4.9**). Two thirds of participants they provided patients with opportunities to ask questions but the majority asked patient if everything is 'OK' while only two participants who asked the patient if they had any questions. However, only two thirds of the participants offered appointments to patients for follow up.

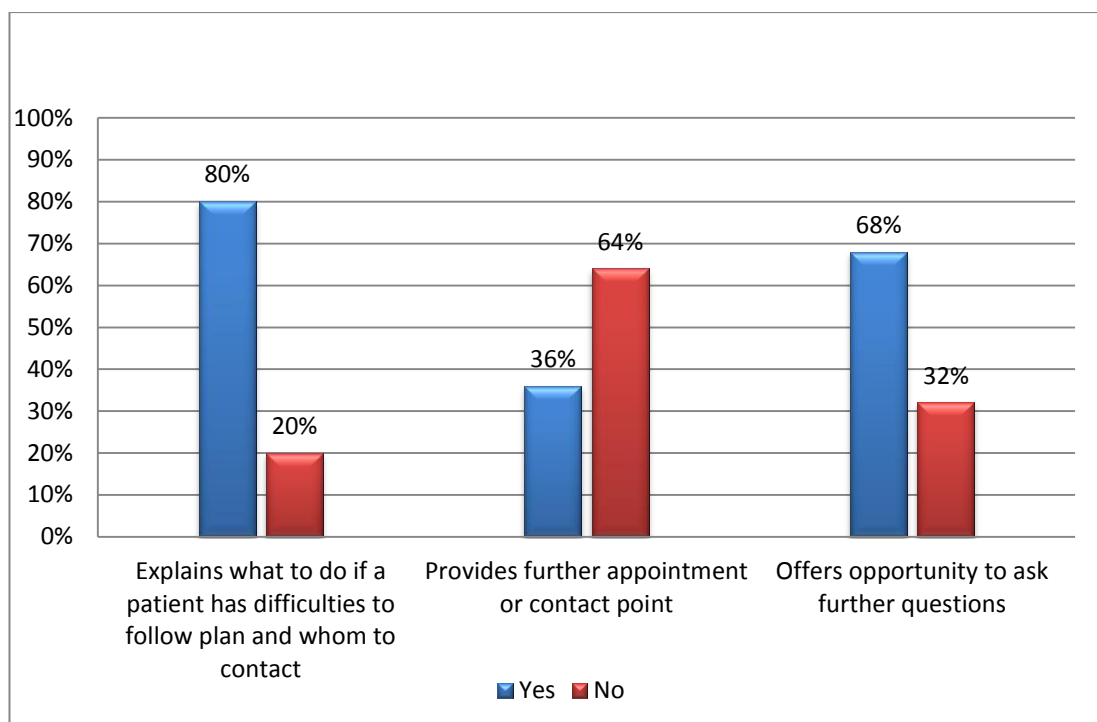


Figure 4.9: Closing the consultation

4.4.5 Consultation Behaviour (Skills Section 5)

The participants (see **Figure 4.10**) did not demonstrated good behaviour when interacting with patients. Less half of participants listened actively to patients and this was demonstrated only when patients asked a question. The participants exhibited empathy during the consultation. However, the participants did not score highly on planning the structure of the consultation and the same percentage scored for using open and closed questions. The participants were more directive and the closed questions were dominant behaviour. Guiding patients toward the agenda of the participants was more likely judgmental behaviour. The participants judging the information they intend to deliver, while this possibly lead to give information which were not necessarily meet the patients' needs. Finally, two thirds of the participants did not manage their time effectively which influence by the agenda of the participants but not the patients.

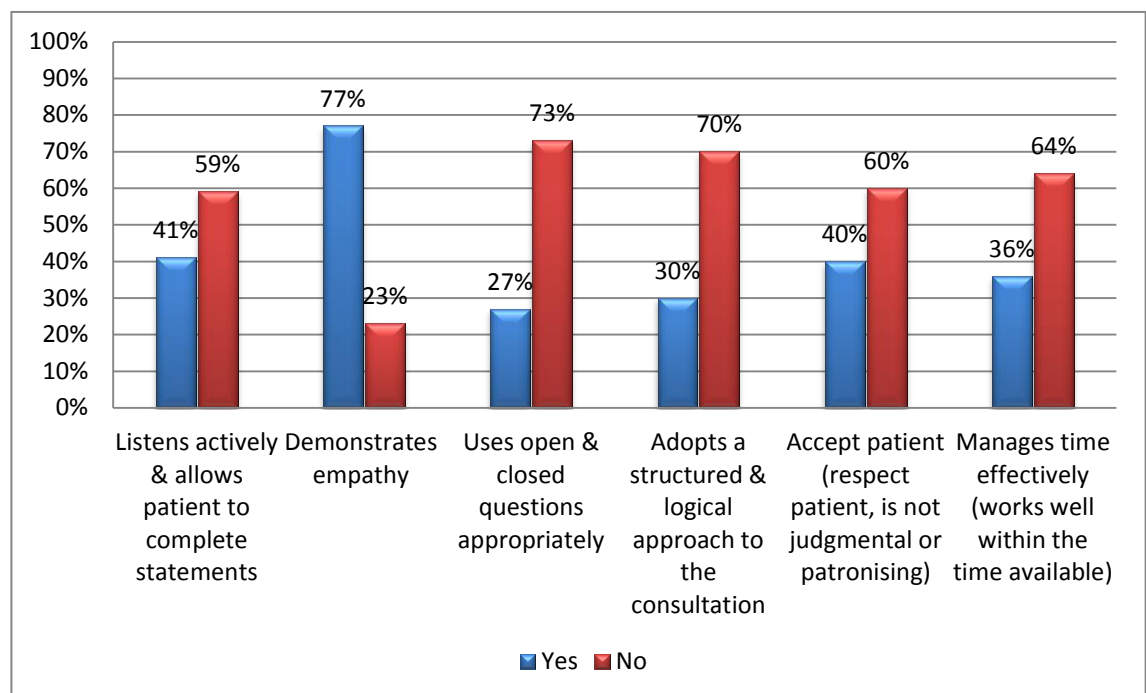


Figure 4.10: Behaviour demonstrated during the consultation

4.4.6 A Comparison of Consultations Behaviour across Sections

Figure 4.11 shows that participants were not particularly motivated to initiate relationships with patients and from the beginning of the consultation, they did not indicate to patients that they wanted to prioritise patients' concerns. However, they showed good skills when eliciting information from patients, but only in relation to prescribed medication rather than social history. The participants provide brief information about the reason for GPs prescribing anti-depressants, which enabled patients to understand their symptoms. Furthermore, the participants gave good basic information about anti-depressants, but they explained the information as a fact and not articulated to individual patients. They scored low on checking patient understanding, and they were not enthusiastic to share information. The patients scored well on providing a safety net and supporting patients. However, the relationships forged between patient and participant was one way, and more likely to be paternalistic in style. In addition, consultations tended to be limited to talking more about 'technical' information about anti-depressants drugs. The participants' agenda was less likely to open the consultation and misunderstand the silence of patients.

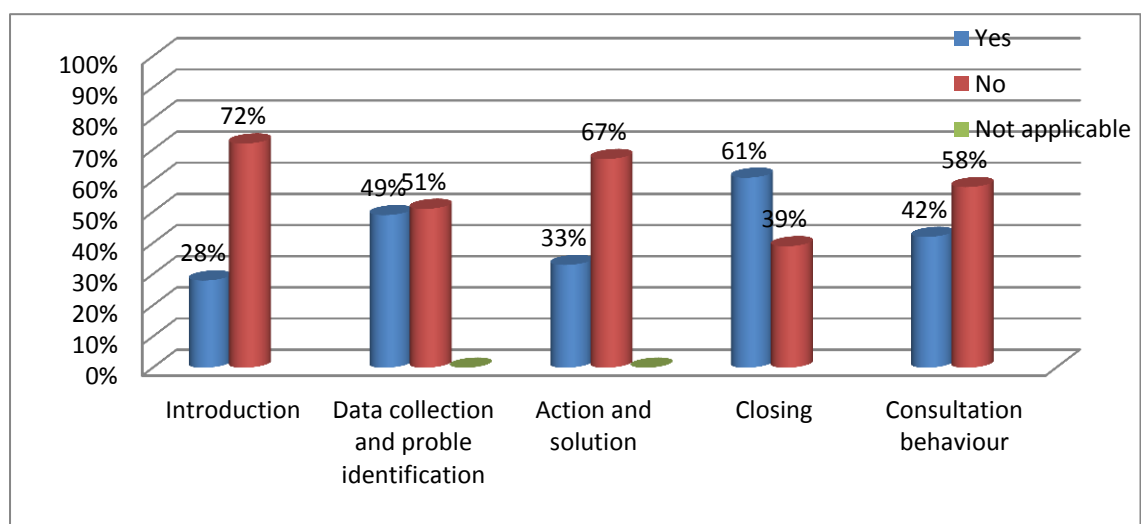


Figure 4.11: Overview of the participants' competence across sections

The above sections described surveys (attitude, knowledge and patients' satisfaction questionnaire) and checklist provides good impression about the current practice of the participants. The quantitative results measure different performance of the participants, for example their skills and attitude, but the researcher thought that adding narrative text but describe quantitative style may provide more feeling both; about participants' intention to engage in this study (Section 4.5) , and their intention to reflect on their practice (CPD) (Section 4.6). Describing the narrative in simplistic style, for example display the account in a table would support the researcher in the discussion Chapter 6.

4.5 The Motivation of the Participants to Participate in this Study

In the section the Gibbs' model of reflection was used to promote and probe the participants, see (Section 3.3.9). There were 22 participants who stated about their motivation to engage in this study. All of the participants (**Table 4.5**) were interested to reflect to on their practice. This is account resulted from recording output. They thought that this research is a good opportunity to enhance their practice and to give feedback. This may indicate that they need to change or enhance their attitude when meeting patients. They found the researcher is good opportunity to perceive about their usual service and the feedback from researcher and patient (simulated) both provide good insight into the participants' practice.

In addition, they mentioned that they need to enhance communication with patients, the majority of them were interested to enhance their skills for more confidence when they advising people with mental illness. It is more likely that these participant perceive mental illness challenging and they need regular feedback, which may tailor to their individual practice. Two of the participants thought the stigma attached to patients and this research may encourage them to take proactive action with people with depression. Two

participants mentioned that came to help the researcher. The majority of participants' opinions seem that they lack regular training through which they assess their practice. It is possibly training about mental illness when involving of patients (simulated) was preferred for the majority. One participant said that before coming for observation he read about mental illness that made updated to his information.

Over all it is likely that the participants lack regular training about mental illness. **Table 4.5** shows the account of the participants.

Table 4.5: Reasons for engagement of the participants (community pharmacists) in this study.

Participants	The purpose of participating in this research as articulated in the words of the participants
Part. 1	<i>To reflect on practice about people with depression</i>
Part. 2	<i>To reflect on practice</i>
Part. 3	<i>To get more personal satisfaction with helping people who have mental illness GPs do not always do their work appropriately</i>
Part.4	<i>To enhance communication with patients who have depression.</i>
Part.5	<i>To gain skills and confidence</i>
Part.6	<i>To gain more confidence when meeting patients with mental illness</i>
Part.7	<i>To make requests for assistance</i>
Part.8	<i>To help me - interest is a good thing to make a difference.</i>
Part.9	<i>Helping your research</i>
Part.10	<i>More learning and feedback - We don't really get audited by external bodies about the sort of points that you sort of get across, so I sort of felt if I just spoke to a patient, maybe that may highlight how I do things or maybe how I should change things in the practice.</i>
Part.11	<i>To gain knowledge of where we stay</i>
Part.12	<i>To reflect on daily work - Trying to be of some sort of assistance - If I can help anybody out - Helping the researcher in his study</i>
Part.13	<i>I'm interested in mental health. During my training I did hospital training and we were on the mental health ward and I saw that the pharmacists could have a big impact there so that's why I thought mental health is good to specialise in.</i>
Part.14	<i>Well the study I thought you were doing was quite interesting and because maybe not a lot of people do come to the Pharmacy to discuss depression with us because it's quite a condition where it's taboo slightly, so it's some research on that, if I could help out then this is something that I'd like to do.</i>
Part.15	<i>I was asked and when I heard about some of the details, it's just an opportunity for me to reflect on my own practice... it's always good to ...refresh your skills or update your skills or get new skills. I've been qualified five years so it's always good to refresh.</i>

Part.16	<i>It's good insight because we don't really get to in Community Pharmacy. I own my own Pharmacy as well, so it's good to see how or what benefit this can do in terms of treating patients. Sometimes you tend to wander off and see the bigger picture. It's good to reflect on your actions and maybe we can reflect on some of the people that work for me as well, staff members and other pharmacists that work for me.</i>
Part.17	<i>I participated because I was interested in knowing more about anti-depressants myself. My knowledge is just what it is from university really, so to come to university was one thing, I just wanted to come back, and, secondly, it was because I wanted to participate and see how I'd perform today really about this.</i>
Part.18	<i>Thursdays/Fridays I work in a prison and I notice that a lot of prisoners are prescribed anti-depressants, so about six months ago I started working and I think when I saw the research on anti-depressants I was like it might be useful.</i>
Part.19	<i>Well the reason why I want to participate is because I've been a locum pharmacist for about two and a bit years and I just, this is a kind of taboo area if you understand what I mean with regards to medication that people take. From my experience, people don't really like to talk about these kinds of things and what I wanted to do is I want to find out what I'm like when discussing this subject with patients.</i>
Part.20	<i>Well one of the reasons, obviously my locum agency they asked me whether I was interested in it and because the anti-depressants we literally give out, that's most of the medication that we give out so anything that I could learn more about anti-depressants it will be helpful. In Community Pharmacy as pharmacists we don't get chance to go through the BNF so it helped me focus on that particular chapter again and read up again about it, so it has helped a lot.</i>
Part.21	<i>To improve my consultation with patients who have depression.</i>
Part.22	<i>I think all research is important especially when they can improve our services. We always can learn something new and even if you think that you know and you deal with the things, it's always good to refresh the things like that so.</i>

4.6 The Reflection of Participants on Current Practice

In this research, an action-plan (CPD) provided short learning activities session for the participants after the initial interviews has taken place and after they had interview with the researcher. This tool encouraged the participants to reflect on their intentions in practice. This tool was adapted from pharmacists' mandatory CPD recording system (General Pharmaceutical Council, 2011) (see Section, 3.3.9).

The data in the **Table 4.6** came from the practice of the participants when they applied CPD in the pharmacy. The documentation of their learning needs and application their practice encouraged the researcher to simplify the data in the table to give a good picture about their intention to practice.

All of the participants (see **Table 4.6**) thought that their skills needed to be improved especially for offering consultation to people with depression. The data showed that the majority of the participants intended to balance between open and closed questions. They thought building relationships enabled them to share information and it is difficult without this relationship. The interview in this research helped them to reflect in their needs. This learning is more likely to make them more confident and provide better services. All of them rated learning need as 'important to very important' to them while the scoring was less when it is relevant other staff (moderate to low). Higher numbers of the participants said they used open and closed question. They try to listen to patients and respond to their cues. They said their goals were satisfactory achieved. A few of them said they need more time to practice and feel out the outcome. One participant said that two patients came again and thanked him. A brief explanation about the journey of the participants through their recording and practicing of learning is explained in the below table.

Table 4.6: Description the participants' intention to develop in practice

Practice	Resources	Individuals	Patients
Identifying learning needs		<ul style="list-style-type: none"> • Majority: building relationships. • Enhance knowledge about anti-depressants and shared information with patients. 	<ul style="list-style-type: none"> • Some participants: Patients satisfaction.
Relevance of learning to practice		<ul style="list-style-type: none"> • Feedback from interview. • High demand for professional practice. • Prevalence of depression is high. • One participant: NICE recommendation. 	
Methods used to identify learning needs	<ul style="list-style-type: none"> • Critical incidents. • Feedback from users of service/product. • Appraisal. • Peer reviews/talking to colleagues, • Their own reading of medical literature. • One participant mentioned looking at leaflets on Mind website. 		
Why is this learning important?		<ul style="list-style-type: none"> • Majority: Knowledge about safety and use of anti-depressants. • Communicating (building relationships, structuring the consultation). • Some: dedicating more time to patients. 	<ul style="list-style-type: none"> • One participant: enhancing patients' awareness of the pharmacist's role. • One participant: non-medical staff and patients.
Importance level		<ul style="list-style-type: none"> • Most participants: very high –high. 	<ul style="list-style-type: none"> • Very high

Ways to achieve learning needs	<ul style="list-style-type: none"> • Majority: NICE and BNF, self-reflection and colleagues. • One participant CPPE, cases • One participant: pre and post satisfaction questionnaire. 		
Evaluation		1. The majority fully achieved. <ul style="list-style-type: none"> • More engagement • One participant : able to recognise symptoms of depression • One participant: more engagement. • One participant: advice of non-medical treatment. • One participant: partly achieved: still building his consultation 	<ul style="list-style-type: none"> • Some participants: Patients' feedback that they were happy, patients appreciated time.
Benefit		<ul style="list-style-type: none"> • More confidence when meeting patients. • Signpost patients to other health organisations. • One participant more interest in helping patients. 	<ul style="list-style-type: none"> • One participant: received two patient feedbacks that were happy. • Some of participants: patients were more open to discussion.

The text below is not exact term of the participants, but the researcher described of what the participants stated. The description step is similar to there in CPD steps.

4.6.1 The Description of CPD

1- What do you want to learn?

All the participants said they wanted to prioritise the development of their consultation skills. They mentioned areas such as 'building a rapport with patients, increasing patient knowledge, increasing clinical knowledge of anti-depressants and their side effects, building better relationships with patients, using open questioning techniques, and tailoring to the needs of each patient'. Participant 16 mentioned obtaining a better understanding of their *role in seeking out additional therapies*. Participant 11 mentioned that the training had increased his *sensitivity towards patients*, which might lead to *patient satisfaction*. He also mentioned gaining *knowledge* and increasing *staff awareness* as key learning goals.

2- How is this learning relevant to practice?

Most participants said that the learning goals were relevant because the feedback they had received showed a need for them to improve their consultation skills. Participant 16 stated that the learning goals of understanding patient needs, providing counselling and advising would help his professional skills in community pharmacy. All the participants said these skills were important in professional practice. Participant 19 stated that improving consultation skills was important to him, because depression was a common ailment that he was required to deal with frequently in practice. Participant 20 said he wanted to be involved in a study on anti-depressants. Participant 21 said that the learning had inspired her to try to improve her skills; she wanted to help improve the way she counselled patients on anti-depressant drugs.

Participant 13 said that learning key counselling skills with reference to BNF and NICE guidance was relevant, because this would enable him to engage with patients and promote a shared understanding of treatments.

All the participants felt that the learning goals were relevant because applying these goals would help them to provide a higher standard of care to patients; guide patients towards the best use of medication; promote better communication with patients; and allow them to engage with different individuals in the community.

Participant 11 mentioned that learning new skills had helped to build his confidence, and this will increase patient confidence in him and in his ability to provide information and support with sensitivity.

3- Methods Used to Identify the Need to Learn

The participants said they used different methods to identify their learning needs, including: critical incident identification, feedback from users of a service/product, audit, appraisal, peer reviews and talking to colleagues, and their own readings of medical literature, for example, participant 7 mentioned looking at leaflets on the Mind website.

4- Why is this learning important?

All the participants said that their learning goals were important because this would help them become more *knowledgeable* and *competent* when treating patients with depression. Some mentioned that it would allow them to offer *more time* and *better advice to patients* and build *better relationships* with patients. Pharmacist 20 said that the learning would help him increase his knowledge about the '*safe use of anti-depressants*'.

Participant 16 said that the learning goals would enable him to provide patients with a '*better service*', and would increase the '*patient's confidence*' in approaching him as a first point of call.

Participant 18 said that the training had allowed her to construct her consultations in a more effective and supportive way. She also mentioned that she felt more '*confident in supporting patients*' with depression at any stage, rather than just advising about medication.

Participant 19 stated that the learning would allow for *full transparency* between him and patients with depression. Similarly, some participants mentioned that the learning had provided them with better skills and, therefore, in turn, the *patients would be more open*.

Participant 12 stated it would make him a '*better pharmacist*' and improve his '*consultation skills*.' Participant 11 mentioned that training had a positive impact on the patient, the pharmacy and pharmacy staff. Participant 8 stated that '*better communication*' would improve advice and information he gave about MURs and NMS.

5- *The Importance of CPD (Continuing Professional Development)*

The importance of CPD was recorded as a mixture of *none, low, moderate, high* and *very high*. Most pharmacists placed '*very high*' importance on their learning goals; some recorded its importance as '*high*', and a few recorded it as being of *moderate, low* or of *no* importance.

The importance of CPD to the participants themselves was *high* or *very high*. Higher levels of importance were placed on the users of the service/products - '*very high*', whereas its importance to colleagues and their organisation was recorded as of *moderate* importance.

6- *What might you need to do in order to get the most from this learning?*

Participant 1 said he would need to practice with more patients in order to achieve his learning goals fully. He mentioned that he is obtaining a CPPE pack on depression, as well as reading case studies on depression. Most participants said that following knowledge based NICE guidelines and BNF would be a good way to achieve learning. Most also mentioned learning through reading clinical pharmacy textbooks, using internet based learning, applying self-reflection, and asking colleagues for advice.

Participant 16 said they would be using patient satisfaction surveys, checking pre and post learning objectives, as well attending more workshops to gain better understanding of the skills of a pharmacist.

Participant 19 mentioned talking to colleagues and attending workshops to achieve his learning goals. Participant 22 said that she would like to engage in open learning, online courses and training with colleagues and staff as a way to achieve her goals.

Participant 21 said that for patients suffering from moderate-to-severe depression she would consider offering one or more interventions guided by the person's preference, such as individually guided self-help based on the principles of cognitive behavioural therapy (CBT).

7- Advantages

The participants wrote down the advantages of their different learning options. Most noted the ease of using web based learning and NICE guidelines, and most participants listed the advantage of being able to provide additional therapies, such as counselling and exercise.

Participant 13 said that attending a workshop with an actor and reflecting on the outcome would help him because he would be able to learn to ask open-ended questions and elicit more information. He would be able to learn to tailor advice to individual patients, rather than offering generic advice.

Most participants mentioned the advantage of talking to colleagues, which will enable them to obtain advice and in a friendly way. Participant 8 said that gaining two-way feed-back was a practical way of receiving expert advice.

8- What have you learned?

All the participants said they had achieved or improved on their goals, and some noted the need for continuous improvement. Most of the participants improved their skills in the following areas: '*communication skills, open style of*

questioning, consultation, tailoring advice, counselling and listening skills'. However, participant 1 noted that although he had improved his skills, '*building relationships*' was not something he could achieve in one meeting with a patient; this skill would need continuous improvement over time. Some participants learned the importance of spending '*more time*' with patients suffering from depression, whereas others learned to recognise the '*different symptoms*' of depression.

Participant 18 said that she had learned to offer *other techniques* to support patients with depression e.g. using CBT, sleep, and hygiene, etc. She had also acquired knowledge on how to build effective and '*supportive consultations*'. She added that she now understood the importance of '*body language and listening skills*' during consultation.

Participant 19 learned the importance of being able to *empathise* with patients with depression, and is now able to obtain information delicately. Participant 20 said that he had learned how to provide '*safe effective advice*' to patients about anti-depressants and inform them of additional treatments such as exercise.

Participant 15 and 7 both said they had learned to '*tailor information*' to individual patients' needs. Participant 11 said he had gained a deeper *insight* into depression and could approach patients using a more '*sensitive/attentive approach*'. He also said that his *confidence* dealing with these patients had improved.

9- Evaluation

The participants gave a mark relating to the extent they felt they had achieved their learning needs, using the scale of '*fully, partly, or not at all*'.

Over half of the participants indicated they had achieved their learning needs '*fully*' and three participants said they had *partly* achieved their goals but that they needed to obtain continuing improvement.

Some participants, such as participant 12 said they had achieved their learning goals '*fully*' and they were now able to recognise symptoms more easily. Participant 1 stated that they had '*fully*' achieved their aims and had improved their confidence to initiate patient consultations and give out extra information; he said that patients would appreciate the extra time he would give to them. Pharmacist 18 also replied '*fully*'. She stated that she now felt confident about supporting people with depression and that she could now offer advice to every patient without any hesitation. She said she would now be able to encourage them to speak up about their issues first, listen to them carefully, and then advise accordingly.

Participant 19 said he had been '*slightly successful*' in achieving his goals but that he was still building his consultation skills. Participant 20 marked '*partly*' because he said he usually experienced good rapport with patients when talking about anti-depressants.

Participant 21 indicated that she had '*fully*' achieved her goals. She would be offering a private area to new patients to counsel them on side effects of drugs, and on how to manage their condition. She also said she would provide information on non-drug treatments to use alongside anti-depressants, such as group or individual counselling.

Participant 11 said he had '*fully*' achieved his goals and he is now more confident in himself and could tailor to suit the needs of each patient. Pharmacist 8 also marked '*fully*' and said he would now be able to give better advice and MURs.

Benefits to Practice

Most participants said that the learning would benefit their practice. They said they were now more confident in the subject area and could signpost patients to other organisations locally. The majority of participant said they had learned better counselling skills, tailoring skills, patient rapport, and improved patient understanding.

Participant 18 said that two patients came back to see her after her first consultation with them and thanked her, stating that they felt much aware about their medication and more confident to tackle their depression. She said that one patient also passed on good feedback that she had received more support from the pharmacy. Participant 19 said that the learning had enabled him to take more of an interest in the patients and their day-to-day lives, rather than in just the medication. Other participants were in agreement with this, and stated that their patients were now more open to discussions and asked for more advice and opinions. Participant 12 said that he had seen benefits to his organisation, was able to *'recognise the symptoms of depression more easily'*, and *'could explain different methods of treatment more confidently'*. Similarly, Participant 15 said he was more self-aware and he could now *'tailor'* to his patients' needs. Participant 8 said he had improved his delivery of information and could now *'engage patients'*, which resulted in better consultations.

The next section will show the satisfaction of patients after the action plan.

4.7 The Patients' Satisfaction with Participants (learning activity)

This section describe the satisfaction of patients with participants who engaged in learning activity (CPD). The patients in this stage were not the same patients surveyed before implementing the action plan, due to reasons mentioned earlier (Section 4.3). One hundred and sixty patients were satisfied to take part and express their experiences with the services in the pharmacy. The most patients who expressed an opinion are middle aged and younger, whereas the least were elderly patients. The number of females doubled the males and the majority ethnicity was white patients.

The number of the participants who took part in satisfaction experience was nineteen. **Table 4.8** shows that patients were not satisfied with the service they received. Only a minority of patients perceived that the participants were willing to offer a private consultation, and the majority (two thirds) divided between being undecided and not knowing at all about this service.

Table 4.7: Patients' demographic factors (after reflection of the participants).

Age	Categories (Years)	Number Percent	Gender	Percent	Ethnicity	Number Percent
After action plan	20-29	35(22)	Male	61(38)	White	106(66)
	30-39	37(23)	Female	99(62)	Asian	36(23)
	40-49	46 (29)			Black	10(7)
	50-59	27 (17)			Mixed	6(4)
	60-69	13(8)			Other	1 (1)
	Over 60	2(1)				
	Total	100.0		160 (100)	Total	100

One quarter of patients did not feel that the participants provided enough information about the proper use of medications, and a slightly higher percentage was undecided about this. It was found that less than half of the participants did not provide adequate advice about the side effects of anti-depressants, and the remaining participants were divided between being undecided about whether they provided adequate advice about anti-depressants and stating they did provide good advice.

Additionally, only about half of patients were confident in the knowledge possessed by the participants, and a third of patients said they were not aware of the levels of knowledge possessed by the participants. Furthermore, although two thirds of patients were confident that the participants were competent in their management of depression (which is good percentage but not high) a minority of patients were not confident about the participants' behaviours and skills.

Less than half of patients wanted more time from the participants but saw that the participants had many other duties to perform. However, the participants were less interested to follow up patient improvement plans and adherence advice. Two thirds of patients either disagreed or were undecided about whether participants must take responsibility for initiating improvement plans, and the majority highlighted the lack of services offered if medications were not available in the pharmacy. Patients perceived that the participants were passive and unaware of their treatment related needs. Finally, less than two thirds of patients said they would recommend the services of the participants to other patients, and the remaining patients said that the services offered by the participants did not meet their needs. Overall confidence of the patients was good but the kinds of services that help patients feel more comfortable and those designed to promote adherence to medications were poor.

Table 4.8: Patients' experience after participants' reflection on their current practice.

Your opinions	Agree	Neither agree nor disagree	Disagree
1. My pharmacist offers to talk to me in private.	59(37%)	37(23%)	64(40%)
2. My pharmacist advises me on the proper use of my medicines.	88(55%)	36(23%)	35(22%)
3. My pharmacist advises me on the adverse (side) effects of my medicines.	73(46%)	42(26%)	45(28%)
4. I have confidence in my pharmacist's knowledge about depression and its treatment.	82(51%)	32(20%)	46(29%)
5. I have confidence in my pharmacist.	104(65%)	19(12%)	37(23%)
6. My pharmacist is available to answer my questions.	96(60%)	40(25%)	24(15%)
7. My pharmacist is willing to talk to me about my symptoms of depression and progress with treatment.	66(41%)	41(26%)	53(33%)
8. My pharmacist helps with the arrangements necessary to obtain my medicines.	94(59%)	42(26%)	24(15%)
9. My pharmacist is aware of my treatment-related needs.	75(47%)	47(29%)	38(24%)
10. My pharmacist responds to my treatment-related needs.	78(49%)	40(25%)	42(26%)
11. I would recommend my pharmacist to other people with depression.	91(57%)	27(17%)	42(26%)

The next section will describe the comparison between basic satisfaction of patient and their satisfaction after the participants received training sessions.

4.8 A Comparison of Patients' Experiences with the Participants

The data in **Table 4.9** includes (pre-post) engaging of participants in learning activity collected did not show any significant differences, especially in relation to age or ethnicity factors that might have impacted on increased or decreased satisfaction. The p-value was non-significant for all questions.

In this section, whenever the term 'before' is used the researcher referring to results obtained before the action plan was implemented, and when the term 'after' is used the researcher refers to results obtained after the action plan was implemented. The scores for the assessment of patient satisfaction varied from one quarter to two thirds see **Table 4.9**.

The results showed that there was no significant difference in patient satisfaction levels relating to the issue of offering privacy after the action plan had been implemented. Slightly higher levels of satisfaction were recorded, but no significant change overall was recorded. Just over the half of the patients said that the participants provided advice about the administration of anti-depressants and less than half were not surprised when this advice was administered. However, even after the implementation of training the participants were still not able to educate patients properly about the side effects of anti-depressants, but more than half the patients were satisfied about the information given out about side effects. The patients did not acknowledge the ability of the participants to manage their treatment, and those who recognised the experience of the participants in comparison to those who did not were comparable. However, confidence and trust levels among patients in relation to the service they received from the participants scored higher in comparison to other services, but the extra training did not serve to increase patient confidence in the participants' skills. Although the participants were seen to change their attitude and dedicate more time to patients after their training, this did not appear to result in significantly higher satisfaction scores. Over one third disagreed that the participants devoted enough time to them.

It was also seen that the participants were not ready to follow-up patients or discuss adherence issues relating to anti-depressants. The percentage of patients who indicated that patients did not follow up was greater than the patients who agreed that the participants monitored their medications and symptoms adequately. Furthermore, other services offered in order to assist patients receive their medicines more easily did not make an impact on levels of patient satisfaction recorded. Overall, the patients expressed the view that the participants only asked about currently prescribed medications, and could not identify patients' concerns or other medication related needs. This meant that less than half the patients did not recommend their friends to the participant pharmacists.

Table 4.9 illustrates the comparison of patients' satisfaction with the service provided by our participants. The term (before) refers before conducting action plan to our participants, and the term (after) refer to after action plan.

The next chapter will discuss the reflection of the participants in practice.

Table 4.9: Met and unmet needs of patients

Your opinions	Agree		Neither agree nor- disagree		Disagree	
	Before	After	Before	After	Before	After
My pharmacist offers to talk to me in private.	55(34%)	59(37%)	38(24%)	37(23%)	67(42%)	64(40%)
	Mean =35%		24%		41%	
My pharmacist advises me on the proper use of my medicines.	81(51%)	88(55%)	39(24%)	36(23%)	40(25%)	35(22%)
	Mean =53%		24%		23%	
My pharmacist advises me on the adverse (side) effects of my medicines.	70(44%)	73(46%)	43(27%)	42(26%)	46(29%)	45(28%)
	Mean =45%		27%		28%	
I have confidence in my pharmacist's knowledge about depression and its treatment.	66(41%)	82(51%)	45(28%)	32(20%)	50(31%)	46(29%)
	Mean =46%		24%		30%	
I have confidence in my pharmacist.	99(62%)	104(65%)	22(14%)	19(12%)	39(24%)	37(23%)
	Mean =64%		13%		23%	
My pharmacist is available to answer my questions.	85(53%)	96(60%)	50(31%)	40(25%)	26(16%)	24(15%)
	Mean =57%		28%		15%	
My pharmacist is willing to talk to me about my symptoms of depression and progress with treatment.	58(36%)	66(41%)	43(27%)	41(26%)	59(37%)	53(33%)
	Mean =39%		27%		34%	
My pharmacist helps with the arrangements necessary to obtain my medicines.	91(57%)	94(59%)	43(27%)	42(26%)	26(16%)	24(15%)
	Mean =58%		27%		15%	
My pharmacist is aware of my treatment-related needs.	72(45%)	75(47%)	45(28%)	47(29%)	43(27%)	38(24%)
	Mean =46%		29%		25%	
My pharmacist responds to my treatment-related needs.	78(49%)	78(49%)	40(25%)	40(25%)	42(26%)	42(26%)
	Mean =49%		25%		26%	
I would recommend my pharmacist to other people with depression.	89(56%)	91(57%)	30(18%)	27(17%)	41(26%)	42(26%)
	Mean =57%		18%		25%	

Chapter 5 Initial Interpretation of Qualitative Data

The researcher would like to summarise the motivation of the participants for participating in this study. For more details see Section 4.5. The majority of the participants who took part in this research said they were interested in enhancing their knowledge of depression. Time is one of the constraints that could affect the participants' ability to improve their knowledge and practice. Furthermore, they said that a stigma attaches to people with depression, and they would like to become approachable practitioners for the benefit of their patients' care. The participants also expressed a need to improve their confidence when communicating with people with depression. The participants talked about how they do not receive regular training in this area, which is a benchmark against which they can evaluate their work. They all said that taking part in this research was a good opportunity to gain peer review and that it would encourage them to reflect on their practice. The demographic of these participants and time associated consultation and interview with will be illustrated in the next section.

The number of the participants was 22 persons. Community pharmacists were 19 and the other three are MPharm students. The majority were male and four were female. The majority of participants age ranged from 18-30 yrs. and third of them were between (31-40) years. The experience of community pharmacists ranges between (1-20) years. The majority of experience is between 1-10 yrs., whereas the MPharm students had training for less than one year. The duration of the consultation ranges between (1-23) minutes and the duration of the interview ranges from 23-83 minutes. For more detail, see **Table 5.1**.

In this Chapter, the results will be presented from the interviews conducted with the participating pharmacists immediately after their simulated medicines consultation. The chapter comprises the five themes that emerged from the interview data (The Attitude of the Participants, The Participants' Engagement with Patients, Tailoring the Consultation, Staging Advice to Patients) see **Table 5.2** includes themes, categories and sub-categories, these elements are

defined to provide more meaning to them. For more information, see **Appendix-20**.

Table 5.1: Duration of the consultation and Interview with the participants

Time of consultation		
Duration of the consultation	All participants	(2-23) Minutes
Average of consultations of all participants	All participants	(7) Minutes
Time of interview		
Duration of the interview	Community pharmacists	(23-83) Minutes
	MPharm Students	(7-22) Minutes
Average interviews of all participants		(36) Minutes

Table 5.2: The relationship between the themes, categories and sub-categories used in this research

Theme	Category	Sub-category
The Attitude of the Participants	A. Nature of Depression	(A1) Causes of Depression (A2) Coping with Depression
	B. Managing People with Depression	(B1) Positive Beliefs about Managing Depression (B2) Negative Beliefs about Managing Depression
	C. Stigma Associated with Depression	(C1) Stigma Attached to Depression from the Perspective of Professionals (C2) Stigma Attached to Depression from the Perspective of Non-pharmacy staff
	D. Time Allocated for Providing Services to Patients	(D1) Participants' Perception of GPs' time (D2) Experience of Time Constraints when Trying to Help Patients (D3) Dedicated Time to Help Patients
	E. Privacy of Patients	(E1) Offering Privacy (E2) Offering Less Privacy (E3) Environment of privacy compared to other health care setting
Participants' Engagement with Patients	F. Training Needed to Engage with Patients	(F1) Role Perception
	G. Lack of Patient Knowledge about the Role of the Pharmacist.	

	H. Lack of Liaison with Other Health Care Professionals I. Organisational Barriers	(H1) Hierarchy of Health Care Professionals
Tailoring the Consultation	J. Developing Skills in Practice	
	K. Initiating the Session	(K1) Negotiating the Patient's Agenda
	L. Giving Information to patients	(L1) Information Sharing about Anti-Depressants (L2) Giving Patients' Opportunity to Talk (L3) Picking up the Patient's Cue (L4) Checking Patients' Understanding (L5) Less Information Sharing about Social treatments
Staging Advice to Patients	M. Quality of Information at First Time Consultation	
	N. Relationship of Participants with patients	(N1) Paternalistic Attitude (N2) Passive Behaviour of the Participants (N3) Building Relations ship with Patients (N4) Relationship Management for Regular Patients
	O. Follow Up Service	(O1) Accessibility of the pharmacist to the patient (O2) Advanced Services

This Chapter describes the diversity of opinion expressed by the participants. They shared their opinions and views about problems such as stigma, time pressures, privacy, organisational barriers, and relationships with other health care professionals. Before starting each theme, the researcher would like to describe the overview as introduction to each of theme, which may give to the reader feeling what to expect the content of each theme. Furthermore, the overview will be supported by external evidence.

5.1 The Attitude of the Participants

Attitude is how people react to various situations and how they explain to other people what they think about what they see (Cherry, 2014). This section places emphasis on the attitudes of the participants towards depression and towards patients generally. To clarify the picture of the participants' performance (attitude) **Figure 5.1** illustrates various influencing factors experienced by the participants when providing services to people with depression.

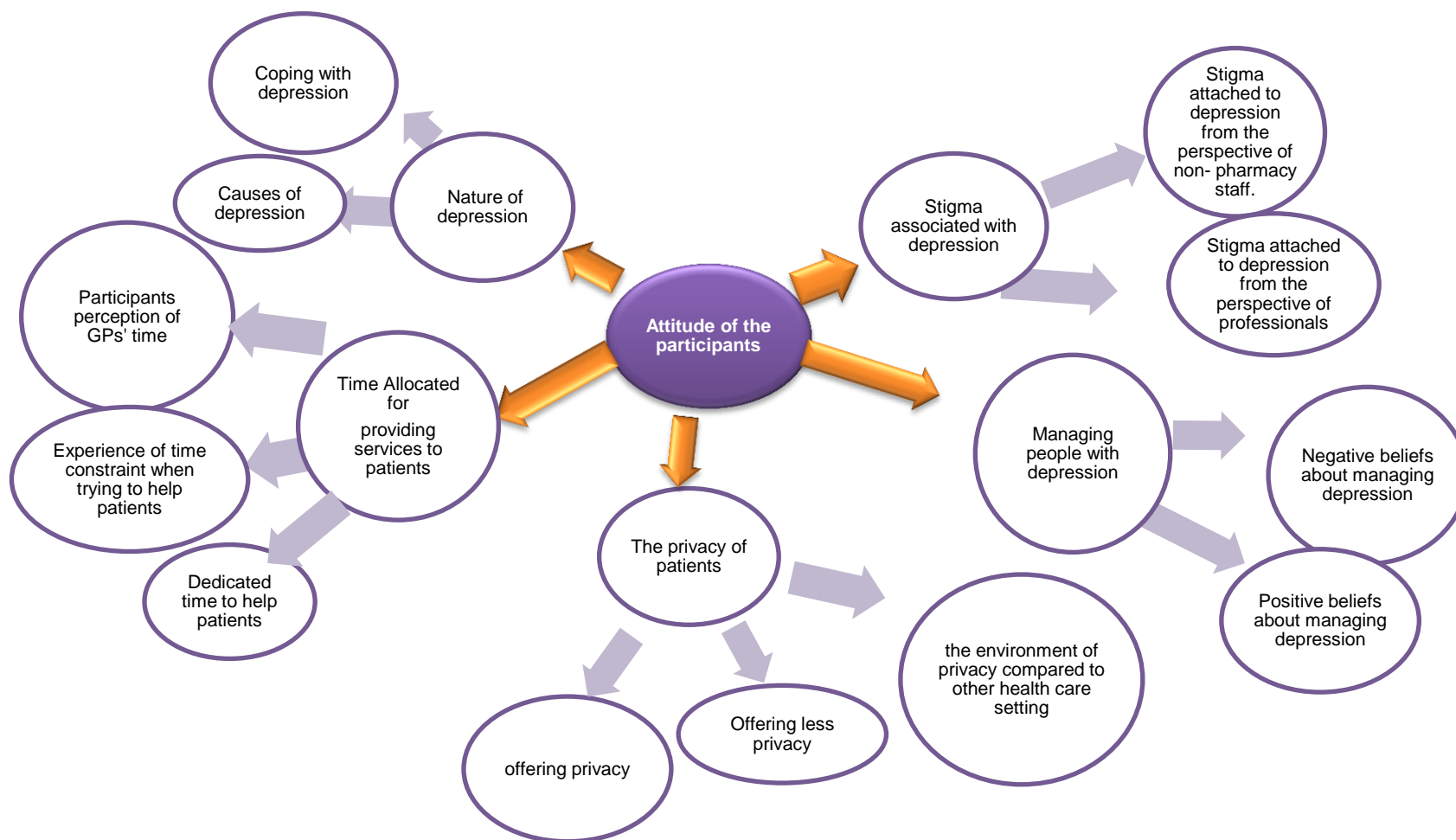


Figure 5.1: Willingness of the participants when supporting people with depression

Overview of Attitudes of the Participants

Depression has many symptoms that can vary from mild to severe and these symptoms influence the pharmacist's perceptions when they interact with patients. These perceptions can include concerns about how patients cope with depression and how to manage patients (O'Reilly et al., 2010 B). Another issue that discussed in this section is stigma. The participants' in this study perceived that patients suffering from depression often experienced different forms of stigma. The behaviour of a patient can trigger stigmatisation from professionals and non-professionals and the impact of stigma affects communication with patients Knox et al. (2013). Time pressures are an important factor that can affect pharmacists who practice. The participants in this study said that, often, physicians do not have time to deliver advice about anti-depressants and that some patients remain unaware of their diagnosis. The participants in this study were keen to help patients and dedicate their time to patient care, but a lack of time is a continuing major issue that often distracts the participants from providing better patient care Chong et al. (2013 C). With regard to privacy, the participants expressed different ideas about the meaning of privacy. However, the majority of the participants said they offer privacy because this enables them to give their patients more attention (Fleming et al. 2015).

5.1.1 The Nature of Depression

Half of the participants made comments in this section. It seems that our participants were more prone toward the social event to cause of depression. Furthermore, they stated that the coping of patients with depression have impact on their treatment's decision.

Causes of Depression (Sub-category A1)

Participants 2, 8, 9, 13, 14, 15, 18, and 19 explained their opinions about the nature of depression. They mostly perceived that lifestyle was the main cause of depression. Participant 14 noted how the effects of physical illness cause depression.

Participant 8 said that social pressure; life events and neurotransmitters factors can trigger depression: life events may include economic issues and social isolation. He said that depression was multi-factorial.

Participant 8: (8 yrs.; qualified; M): Well you've got your environmental factors, so it's the surroundings and the people around them...also it is, it is a physiological factor as I was saying about Serotonin.

Coping of patients with depression (Sub-category A2)

The participants said that depression presented with many symptoms that make coping with the illness difficult. They noted reluctance among patients to receive information from their healthcare providers, and they expressed concerns about an absence of participation by patients in their treatment decisions. The participants compared the severity of depression with other physical health conditions; most of the participants held the attitude that physical diseases are not as severe as mental illness.

Participants 2, 3, 9, 10, 13 and 15 thought mental illness is more intense than physical disease and they used the term 'hard' to articulate their idea of the intensity of depression. This possibly imply that the participant feel difficult to deal with people with depression.

These participants said that depression can affect mood and that patients might feel they have less of a grasp on life, Participant 3 feel patients '*full of fog*'(These participants reported symptoms included a loss of interest and low energy. However, Participant 2 noted how people with depression often exhibit a variety of behaviours to cope with depression. Depression has many symptoms that make people feel sad and have low self-esteem. People who have depression are more likely to mask their symptoms than people do when they are suffering from physical disease. For example, they try to be happy when they are sad and be active when they feel weak (Richards, 2014).

Participant 2 said that some patients show some self-worth, but when it comes to discussing their concerns and feelings, depressed patients are more likely to be emotional. This could imply that these symptoms could be barrier for patients to talk with the participants. In agreement with, most patients who experience depression describe feelings of helplessness and hopelessness: they feel a loss of energy and are agitated and restless. Depression produces a negative impact on everyday life, either at work, or at home, and in the family (Van Geffen, et al., 2011

Participant 2: (12 yrs.; qualified; M): So it depends on how good they are at disguising that and how good they are at; it depends on how they approach that... There's some classic signs that people would be able to see across the street that someone's depressed, but actually...because some people come in and they're sort of all jolly and it's... you can tell it's an act. You can tell it's not really that ...for the two minutes it takes to have a conversation it's quite easy not to appear depressed if you see what I mean.

Participant 3 said that the symptoms of depression can have an impact on understanding the advice about their medications, patients are less interested in receiving information about non-medical treatment, and they are more likely to take medications if they understand their medications. This quotation below revealed that the goal of the participant is to encourage patients to take decision about their medication, especially when the severity of the symptoms is possibly a barrier for patients to take their medications.

Participant 3: (15 yrs.; qualified; F): ... patients who are pretty rock bottom...quite, they're hard...in because you're full of fog Their lifestyle issues would, are really so minimal in comparison to the here...If I said to you now, you're rock bottom and you just need to know, kind of tell me how long it's gonna take to kick in and what do I do – take one a day and I said and do you smoke? Well, what?

What? Stopping, I'm not stopping smoking right now! What planet are you on?

Participant 9 said that depressed patients are more likely to be introverted when interacting with other people and this introversion makes it hard for the pharmacist to be aware of their patients' needs.

Participant 9: (4 yrs.; qualified; M): They don't want to speak to anyone, there's no counselling involved so yes it's... because the Mind might be saying something else but the heart's saying something else, so they've got to control their emotions inside.

Participant 10 said that the behaviour of patients who experience physical diseases varies in comparison to those who suffer from mental illness, and noted that patients who have physical diseases are more likely to raise their concerns with the participant than with patients who have depression. This participant thought that symptoms of depression cause people to be introverts within their community. This could indicate that the participant feel difficult to start conversation with introvert patients.

Participant 10: (11yrs.; qualified; M): But if you have a mental issue, I can't see that. If you've got a broken leg, I can see that looking at your leg...you need to go but where there's sort of mental issues, I think that people still sort of hide them issues. You know, sort of put happy faces onto other people like everything's okay when everything isn't okay...

Participant 15 felt he was unaware of the behaviour of patients who are trying to cope with depression. This participant said he is less involved with patients and unaware of the coping behaviours of depression, but he also noted that patients are reluctant to talk about their experiences of depression. This possibly indicates that the participant less confident to engage with patients.

Participant 15: (3 yrs.; qualified; M): In terms of coping mechanisms, I'm not that much engaged in terms of what patients talk about with respect to things non-pharmaceutically.

In summary, the symptoms of depression made the patients, introvert, passive and unwilling to communicate with the participants. Similarly, the participants perceive hindrance to manage people with depression. In consistence to, over half of pharmacists agreed that people with depression are less willing to talk. The authors suggested that these beliefs might have impact on pharmacist when communicating with patients, that pharmacist less likely to provide pharmaceutical care to patients (Liekens et al., 2012).

5.1.2 Managing Depression

This section will outline the different attitudes of the participants towards the treatment of depression in comparison to other physical diseases. Participants 1 and 14 held positive attitude toward managing people with depression, they thought that depression is treatable in a shorter time span than physical diseases. Unlike, Participants 9, 10, 13, and 20 held less favourable attitude, they said that the severity of the side effects of depression are difficult to monitor, and felt that educating patients about their condition is harder when dealing with people who have mental illness in comparison to those who have physical diseases.

Positive beliefs about managing depression (Sub-category B1)

Only two participants felt that managing mental illness is similar to managing other physical diseases. Participant 1 attempted to correct incorrect perceptions held by patients about how mental illnesses are more difficult to treat than physical illnesses. His approach for building up self-esteem in patients was implied by his repetition of 'I always'. He said that he always makes conversation with people who have depression and he tries to reassure them that they can be relieved of depression. Possibly, this participant feels that depression is associated with psychological and social factors are more

manageable than physical disorders that are more difficult to cure. However, this participant demonstrated a positive attitude towards providing services to people with depression.

Participant 1: (5 yrs.; qualified; M): ...look with diabetes you know lifelong treatment because you're not going to all of a sudden, you know, cure your diabetes, and with blood pressure you're on it more or less... it's lifelong in that respect.

Negative beliefs about managing depression (Sub-category B2)

In contrast to the previous section, Participant 9 expressed negative beliefs about anti-depressants. She said that anti-depressants produce serious side effects that can possibly make patients worse, for example, give them suicidal intentions.

Participant 9: (4 yrs.; qualified; F): You're not causing any long term or any damage to the patient...but that does not necessarily mean that it's actually going to benefit them in any way because they can still go and commit suicide, they can commit a crime.

In agreement with Participant 9, Participant 13 said that treatments of physical diseases are easier to monitor compared to those for mental diseases. Participant 13 noted that there are standard measurements to assess relief for patients from hypertension for example, and these measurements include taking blood pressure that gives an indication of the recovery of the patients. Furthermore, this participant said that his knowledge about physical diseases is greater than that for mental illness that, he said, is difficult for him to assess when it comes to measuring the improvement of people with depression.

Participant 13: (5 months; qualified; M): Because if the diabetes is controlled you do a blood test and blood sugar is controlled, it's very easy, but how do you decide if this is working? You can't...like if I

was counselling somebody on a diabetes drug like Metformin, it's very clear what they need to know, but if it's related to the Mind and to behaviour, you need a lot of time.

The participants who held negative beliefs about the management of depression said it is difficult to deal with patients who had depression, and they thought that depression more intense than other physical diseases. Guillaumie et al. (2014) finds it is difficult for pharmacists to assess the relief of patients' symptoms. The same study finds that pharmacists believe that depression is a challenging condition and that pharmacists feel more comfortable when having contact with a patient who has a physical disease.

Bell et al. (2006 A) finds no difference in social distance scale among students of pharmacy and graduates toward people with depression. The workplace and having education about mental illness had less influence on the attitudes of these participants. A possible reason is that education at university is limited to the action and safety medications but practice in pharmacy focuses on the experience of patients with diseases (Bell et al., 2006 A). Van Geffen et al. (2011) identify patterns linked to the discontinuation or continuation of the medications. The study finds that patients discontinue anti-depressants when they are less involved in the decision-making.

5.1.3 The Stigma Associated with Depression

This section deals with the stigma that people attach to depression. All the participants felt that the level of stigma surrounding those who suffer from depression is high in the community. They said that this stigma has increased due to negative views held in the community towards patients with depression. Participants said that the stigma begins when patients visit professionals. The participants described different behaviours that patients might exhibit to try to reduce perceived prejudice by pharmacy staff and other patients in the pharmacy.

Stigma attached to depression from the perspective of professionals (Sub-category C1).

Half of the participants except 2, 4, 7, 8, 9, 10, 15, 17, 19, 20 and 22 stated that patients experience stigma when meeting the participants. Participant 4 said she experienced instances where stigma had been attached to patients with depression. She said that professionals unintentionally stigmatise patients, for example through non-verbal behaviour. As a result, patients are more likely to misinterpret the behaviour of pharmacists and perceive that the pharmacist holds a negative attitude.

Participant 4: (MPharm Student; F): Because you want to be really careful not to upset them. But you want to make them know that, you know, it's nothing to be ashamed of because there's quite a stigma attached to it. Because you don't want people to think that, you think anything negative of it because anyone could be in that situation.

Nonetheless, participant 4 said she is keen to encourage patients to eliminate their negative thinking about stigma and she tries to build self-esteem in patients. This kind of approach indicates that this participant has a positive attitude towards dealing with mental illness. Furthermore, Participant 15 said that feelings of stigmatisation emanate from the behaviour of professionals.

Participant 15: (3 yrs.; qualified; M): I think I don't want to labour the point, but if I place depression in the same category as diabetes, asthma, or gout for goodness sake...there's no need for me to think that other people will think bad about me in that, because I think obviously when you suffer from diabetes or asthma people don't look at you in a way that you're weak.

Participant 15 said that people with depression often self-stigmatise and these patients are more likely to interpret communication negatively when the pharmacist engages with them, especially if the pharmacist has to discuss

personal lifestyle. The self-stigmatisation patients demonstrate can distract a pharmacist during a consultation. This circumstance seems to arise more frequently in patients with depression rather than in patients who have physical diseases. This means that pharmacists are less likely to give advice about medications to patients who suffer from depression.

Participant 19 said he came to this conclusion due to 'non-verbal cues' from patients. He said that patients avoid eye contact and that could mean they are not ready to listen to instructions. The participant did not take the cues as advantage to start discussion to explore patients rather than the participants assumed that the meaning was clear.

Participant 19: (3 yrs.; qualified; M): And then you could tell if they weren't feeling, you know if there was a stigma because they'd be maybe looking away or maybe they'd, they'd you know, they'd be all hunched, maybe they wouldn't want to speak freely. They wouldn't have good contact. Or maybe they would say oh you know, I haven't got much time or something. That would indicate to me that they wouldn't feel comfortable talking about it.

Participant 22 said she made decisions not to engage fully with patients if the patients had already refused an offer of consultation. Patient 22 said that patients with depression are less willing to talk about their treatment. It is possible that that these patients are willing to talk when the participant is active and start the conversation.

Participant 22: (10 yrs.; qualified; F): you see from my experience it will be like oh yes, I'm not feeling well. Oh yes, but that's home, that's all home, but that will be okay if I take that medication. I think that they don't really want to discuss what's really going on, why they're in a situation like that, maybe because they feel a bit of shame as well.

Stigma attached to depression from the perspective of pharmacy staff (Sub-category C2).

A pharmacist's role extends to consultation about medications with a patient and checking prescriptions. What might help is for non-medical personnel who work in the pharmacy to perform non-professional work; this might save the pharmacist time and enhance his or her practice. Nonetheless, the lack of qualifications non-medical staff might have to deal with people with depression can raise concerns. Non-medical personnel are usually the first people who meet patients in a pharmacy and they are the first people upon whom patients form an opinion about the whole pharmacy and, therefore, about whether or not to accept support (McMillan, et al., 2014).

Participants 2, 4, 6, 9, 17, 19 and 21 believed that non-professional personnel influence patients to seek for help. Participant 6 commented on the stigma attached to people with depression. He said that patients experience emotional pressure when in the presence of other patients in the pharmacy who might not have depression, and this might increase their desire not to linger in the pharmacy. Furthermore, Participant 6 said that patients were likely to be concerned about the presence of non-medical staff serving in the pharmacy and this might lead to a communication barrier forming between patients and the staff in the pharmacy. For example, non-medical staff might hold negative attitudes about depression or show a lack of proper understanding about depression. This participant said that stigma using the consultation room might reduce stigma because this sends out a strong message that the pharmacist is not the person applying the stigma.

Participant 6 said that without the option of privacy, patients might not stay in the pharmacy. However, it is likely that patients are not yet ready to listen to advice from pharmacists generally, and this influences the provision of care to patients. This participant raised another point from experience saying that feelings relating to stigmatisation might increase when patients are familiar with staff in the pharmacy, especially when they know these people in their

neighbourhood. He said that when his mother had depression, she found difficult to visit her local pharmacy and so she decided to collect her anti-depressants from another pharmacy located some way from her home. His mother's worries about stigmatisation encouraged her to collect her anti-depressants from another pharmacy.

Participant 6: (MPharm Student; M): ...they don't want to talk about it because they don't want other people to know, and if it's a local pharmacy as well, they may actually know these people that are in the store ... I mean my mum knows everybody where she lives so it is worthwhile having a consultation room to the side where you can just remove that distracting environment, that possible anxious environment, for the patient.

Participant 9 felt that the presence of non-professional staff in the pharmacy might increase feelings of stigmatisation for people with depression. This participant said that non-pharmacists usually do not offer any verbal support when serving customers and this might give the impression that pharmacy staff cannot help. This participant said that non-pharmacists are usually 'very *hesitant*' to offer any advice for professional reasons, but this can imply a cautious attitude generally about the pharmacy. Furthermore, this participant gave examples of how difficult it might be for staff to engage with people with depression in comparison to those who do not have mental illness.

Participant 9: (4 yrs.; qualified; M) What it is, they don't know how to handle...I find that my staff are kind of very hesitant...but when it comes to something like this, they kind of go hum I don't know what to say, because you don't know what they're thinking, what the patient is thinking.

To summarise this section, people with depression often perceive stigma. Feelings associated with this stigma can arise when they visit the pharmacy and the pharmacists noted that, sometimes, these patients are less likely to engage

with them. The opinions held by the participants reveal that they make negative stereotypes. The participants' perception is their decision to communicate with patients rather than taking active role and explore patients. In accordance with, Lilja et al. (2008) argues that pharmacists misinterpret the silence of patients who might be more open to discussion more often than they realise. Moreover, enhancing the skills of non-pharmacists who serve in pharmacies could help to tackle the negative stigmatisation of mental illness and the negative feelings that are associated with stigma.

Knox et al. (2013) use semi-structured interviews to find that some people with depression perceive stigmatisation in the behaviour of staff in the pharmacy and from other patients in the pharmacy. The study suggests that the negative attitudes of health care providers are reduced by enhancing their knowledge about mental illness. Possibly the awareness of mental illness could change the negative feeling about mental illness, Lam et al. (2015) find that practitioners who have a diploma in mental illness are more likely to hold positive attitudes towards mental illness than those who have not had any formal training.

5.1.4 The Time Allocated to Providing Services in the Pharmacy

This section explores three sub-categories in relation to the amount of time dedicated to helping patients in different medical settings. The first sub-category shows the participants' perspectives of the physician's time-line. The majority of participants felt that physicians do not have enough time to provide adequate information to them about depression and anti-depressants (Tarn et al., 2009). The second sub-category explores the pharmacists' time constraints that affect the provision of care provided to patients (Barney et al., 2011). The third sub-category illustrates the willingness of the participants to dedicate their time to helping patients (Latif and Boardman, 2008).

Participants' perception of GPs' time (Sub-category D1)

Participant 9's comments agreed with those of Participants regarding physicians' limitations of time. This participant said that the investigation

conducted by a physician in such a short space of time was not enough for physicians to involve the patient in discussions about their treatment. This short time span allocated for investigating patients and getting an understanding of their illness means that, often, people with depression experienced misunderstanding.

Participant 9: (4 yrs.; qualified; M): It's just ...it's just common practice really...you have that 8-10 minute slot ...by the time a prescriptions done, you know you've only got about 3-4 minutes diagnosis time and doctors do not really have much time from past experience to go through in detail what the patient is receiving, what they're getting, what side effects they should be experiencing, nothing whatsoever and that is coming with the four yrs.' experience that I've had and hence...

In line with the comments made by Participant 9, Participant 10 said that time pressures mean that physicians are unable to provide medication advice to patients, and so patients are dissatisfied when they visit the pharmacy. However, the participant is usually keen to assess patients' awareness about their anti-depressants and address important questions about anti-depressants.

Participant 10: (11 yrs.; qualified; M): If someone has it for the first time...what I sort of find is that GPs don't really have the time to really sit with them and say, look this is the medication, this is how it works, this is how you feel and...how long it will take to work, what they should do if they're concerned about a problem, what other options are available?

To summarise this section, patients are unlikely to engage about their treatment with their physicians. This is possibly because physicians work to tight time constraints and do not have time to educate patients about their medications. Time pressures affect the way professionals to communicate appropriately with patients. Anderson and Roy (2013) suggest that people with depression are

dissatisfied with their physicians, that they lack intention, and are dismissive. They find that physicians cannot conduct effective consultations for patients within a ten minutes timescale and some patients left the physician's surgery without gaining much from their consultation.

Experience of time constraints when trying to help patients (Sub-category D2)

All the participants experienced time constraints. They all felt there are many commitments to meet in the pharmacy and these take priority over time spent with patients discussing medication. The participants' said they prioritise dispensing and checking prescriptions, but do not develop verbal communications with patients. They said they spend only about a minute communicating drug information to people with depression. Participant 7 said that lack of time is a major obstacle in their practice. He said he is unable to help every patient thoroughly and this creates a barrier to providing a better service. Making time for interacting with patients becomes an issue unless the patient specifically asks for further information.

Participant 7: (8 yrs.; qualified; M): But I may not have had, well, I may not have spent enough time with the patient...depends on how many other people are there or not...I would say timing, because there are other people waiting for their prescriptions... In a normal day-to-day pharmacy then unfortunately we'd love to spend more time with everybody...again probably not an excuse but timing. So you get used to trying in that short time, getting as much information as you can.

Participant 19 said that, when she is advising, her attention is usually on other patients and what he is going to do next. The interesting point was that this participant felt that she prioritised other patient who may need to collect their medications rather than spending time for one consultation. This approach might build-up negative feelings in patients and might make them reluctant to ask for any clarification associated with their treatment. Similarly, Participant 19

said she had less time to share information with patients than she wanted and so did not plan to dedicate more time to communicating with patients. This implies that patients are not being educated about their medication.

Participant 19: (3 yrs.; qualified; F): What I meant by not having time is that you know, if there's somebody else that needs serving or there's about four or five prescriptions that need checking to go out immediately after this then obviously I would just make sure that prioritise (other patient not the one who need consultation), that I wouldn't you know spend 10 to 15 minutes talking to one patient and then people are waiting you know in my experience people don't like to wait in a Chemist so I would you know, I would prioritise it like that.

Participant 20 explained that he plans only a short time for communication with patients and this amount of time is not enough to provide information about antidepressants. He said '*it took two minutes*'. This indicates that the patient's agenda was less likely to influence time spent on giving out information.

Participant 20: (29 yrs.; qualified; M): So that's why they're not in there... literally takes me two minutes, actually less than a minute to explain... you can't, you don't have time to take the patient in the consultation room... I don't think any pharmacies turn down, we say okay. We'll say to our healthcare assistants, can you just tell them we'll be five minutes. We do what we have to do and we'll just say to them, increase the waiting time.

Participant 20 said he usually ignores patients when they ask for help because he is so busy and cannot be responsive to patients' needs. He said it is likely that the patients know the kind of advice he can, as a professional, give but time pressures work to eliminate his concern for patients.

Participant 22 said she is aware that her communication with patients is ineffective. She said her busy environment influences her and she is unable to

change her method of practice. She knows that the patients are not being educated about their medications.

Participant 22: (10 yrs.; qualified; F): It might be like patient don't want to know or maybe Pharmacist had no time to give the proper counselling, proper information.

To summarise this section, the participants are only able to put aside a very short amount of time for providing consultation services to patients, and this means they are less likely to share relevant information with patients. Moreover, these time pressures prevent the participants from picking-up on non-verbal cues from patients. Likewise, patients are less likely to receive satisfactory advice that can help with the self-management of their drugs. This could mean that patient less expectation about the role of pharmacists, and possibly enhance patients' expectation that the pharmacist role is for dispensing. In agreement to, the majority of the pharmacists in their study lacked the time to spend with patients to provide more advice. Time pressures are the main barrier to achieving patient satisfaction by Chong et al. (2013 C). Limited time is a barrier to effective consultation with patients by Hwang and Young (2015).

Community pharmacists perceive a gap between the current and actual work in the pharmacy. Laliberté, et al. (2012) report that 86% of pharmacists' believe time is the major obstacle to providing support and screening to patients and 21% lack skills or knowledge. However, the study does not cover mental illnesses.

Dedicated Time to Help Patients (Sub-category D3)

The majority participants all expressed their will to provide services to patients and they said it is their responsibility to give patients advice. Their responsibilities can include understanding patients' concerns about depression and helping to make sure patients benefit from anti-depressants. The pharmacists all said it was essential to be able to devote time to patients for

consultations. The information given in a consultation about anti-depressants, particularly with newly prescribed patients, helps a patient know what to expect when taking anti-depressants.

Participant 1 expressed his keenness to help patients, but said this engagement with patients does not happen unless he specifically dedicates time to them. He said that he regularly finds time to spend talking to people with depression. He used the words '*opportunity*' and '*opportunistic*' when describing his behaviour. This indicates that he considers prioritising available time for patients as a good method of imparting information. He is committed to developing relationships with patients and he prioritises this activity over other commitments.

Participant 1: (5 yrs.; qualified; M): I try to take more time out for my patients that are anti-depressants...I felt good opportunity, opportunistic, opportunity patients... presented with an anti-depressant script especially because it's first time, so take the opportunity to talk in a little bit more detail about the medication and the treatment plan.

Although Participant 1 has many responsibilities at his pharmacy, he prioritises patients over all the other services he provides at the pharmacy. Nonetheless, spending time with patients does not necessarily ensure that the quality of information given out is good. His response indicates that patients appreciate his efforts, but this statement 'may or may not be confirmed' by his patients. If true, his patients might indeed be grateful for the time he spends with them and his advice, especially if this helps to alleviate particular concerns. However, we do not know how the participant has formed his judgment, so the perception of his patients' satisfaction might be false.

Participant 1: (5 yrs; qualified; M): ...because they've, you know, appreciated that you've taken 20 minutes out of a busy day to...

Participant 2 talked about the importance of providing time for patients. He said that some patients experience issues and concerns about their medications and they probably lack the confidence to self-manage their medications. The participant said that providing sufficient time for patients helps him to listen actively to patients, and this means he can eliminate his patients' concerns. The consequence of giving time to patients is that these patients feel satisfied and demonstrate verbal thanks, saying that they appreciate the pharmacist's time.

Participant 2: (12 yrs.; qualified; M): Some people are very grateful. Some people are like oh thank you, you've made me feel a lot better about it. I was worried about these tablets before, now I'm a lot happier.

Participant 21 said it was important to spend time with patients suffering from depression to make them aware about the safe use of anti-depressants. This participant was willing to spend time with patients, especially if they had not taken anti-depressants previously. The participant said she wanted to make sure patients were '*using their time as much as possible*' which could indicate that the participant perceives that it is important to check the patients' understanding of the information.

Participant 21: (2 yrs.; qualified; F): It was a new drug I knew that I needed to spend some time explaining what it was... the role of the pharmacist is important for using their time as much as possible to clarify any issues or answer any questions the patient might have.

To summarise this section, allocating available time in practice can help the pharmacist check the patients' understanding of the drugs taken and can help pharmacists to pick-up on patient cues. This approach also builds relationships with patients. The indications are that patients value the time dedicated to them for eliminating their concerns, and this enhances their experience of the service. However, participants who stated that they dedicated time to patients also stated in the previous section that they did not have enough time to offer

consultation to patients and dedicating time may distract them from their workload. Sheridan et al. (2012) find that time dedicated during the consultation is a poor proxy for quality when there is less engagement between patients and their health care providers.

The next section will illustrate the role of privacy in practice.

5.1.5 Privacy

The majority of the participants reiterated the importance of patient privacy. This section will explore the decisions made by the participants' relating to offering privacy. The participants expressed different opinions about the meaning 'privacy'. Some participants said that privacy meant preventing others in the pharmacy overhearing conversations between themselves and patients. The participants described role of privacy in communication. Participants noted the advantages of offering privacy when trying to build relationships with patients. However, one participant was less optimistic about the 'privacy' that can be offered to patients in pharmacies in comparison to the privacy that is offered in other clinical settings.

Offering privacy to patients (Sub-category E1)

Participant 4 believed that the number of other patients in the pharmacy at any one time is more likely to increase feelings of stigmatisation experienced by patients with depression. She said that patients are less likely to raise their concerns at the dispensing counter and consultation room provide a comfortable atmosphere for patients to talk in. This indicates that the pharmacist values the patient's autonomy.

Participant 4: (MPharm Student; F): If I sense a patient feels a bit nervous... I'd ask them if they'd want to go to a consultation room because in practice you'll probably have loads of other people around and a queue of people and they might be worried that

someone's going to hear themthat they work with ...or something ...and...so give them more privacy.

Participant 9 said that offering a consultation room means he can devote the right amount of attention to patients due to privacy, and that communication exchanges improved when it is possible to use eye contact. This participant explained that he is more likely to listen to patients and understand their concerns and this facilitates empathy with a patient.

Participant 9: (4 yrs.; qualified; M): ...if they haven't had it before I invited them into the consultation room to make it more private and make it a bit more warm for them and keep as much eye contact as possible as well.

Using a consultation room gave patients the opportunity to discuss issues with Participant 11. This participant said it helps to reduce the stigma felt by patients due to the presence of other staff and other patients in the pharmacy. He said that offering privacy has helped to change the perceptions of patients because they are able to move from the dispensing environment to a quiet environment in a consultation room. This participant said that offering privacy to patients helps patients feel respected. Moreover, Participant 11 said that using a consultation room means that no other people can overhear, and this includes non-medical staff. The participant implied that patients become concerned when overheard by others in the pharmacy.

Participant 11: (18 yrs.; qualified; M): like I say it's, you know from a setting into shop floor to a consultation floor already gives not just the patient the privacy, yourself the privacy as well so you feel a lot more comfortable in actual discussing what you need to discuss without feeling that the patients thinking one thing or thinking they're being overheard or someone's just walked in.

Participant 14 felt that offering a consultation room was not only about preventing others overhearing, but also about helping to build relationships with patients.

Participant 14: (3 yrs.; qualified; M): One was the quiet room, consultation room so in a quiet, closed environment where the rest of the World is kind of sealed off. You have more of a chance of engaging, more of a chance of talking and the patient can express themselves a bit more comfortably.

Participant 14 said that patients are more likely trust a provider when the patient's legitimacy and values are respected this could create good relationships through the engagement of patients with the pharmacist. Offering a consultation room provides more privacy, encourages patients to be comfortable, and encourages them to raise their concerns; patients feel that the consultation room offers them a closed environment, especially when they move from the counter to a confidential environment (Fleming et al., 2015). Nonetheless, most participants in this study said that a consultation room is not always used and they are more likely to offer privacy for first time patient visits.

Offering less privacy (Sub-category E2).

Workloads in the pharmacy had an impact on the decisions made by the participants. Participants 4, 7, 8, 10, 17 and 19 made comments on this section. Participant 7 said that it was important to maintain a balance between performing other commitments and offering a consultation room to patients. This participant said that the busyness of the pharmacy contributes more to his decision-making than the lack of desire to explore patient needs.

Participant 7: (8 yrs.; qualified; M): So I mean normally I wouldn't always take them into the private room but I'd have a quiet chat if; depends on how many other people are there or not but I would

always ask whether or not they've had the medication before and I would always say it can take a few weeks to start working.

Participant 10 said that patients are not overly interested in using a consultation room, because this gives the impression that the patient's condition is serious, and so this participant did not offer the opportunity for patients to receive information in a private room.

Participant 10: (11 yrs.; qualified; M): But it's sort of difficult because what I find is people that are feeling sort of low mood, sometimes it always quite hard to sort of say to them follow me in the consultation room because I think that sort of closes the actual space and I think people can sometimes feel; basically it's like putting an animal in a cage.

Participant 17 said that he offers privacy at the counter desk if no one else can over-hear the consultation. This participant used his perceptions to assess what the patient wanted rather than offering consultation room. He said that his pharmacy assistants are often busy with other commitments and this means they are not able to overhear consultations. Moreover, he said that the assistants at his pharmacy hand out a significant amount of anti-depressants and so they have a positive attitude towards people with depression anyway. Participant 17 is less aware that a consultation over the counter indicates to patients that patients tend to associate an over the counter chat with non-professional services and a consultation room chat with professional services. This participant uses his perceptions to make decisions rather than offering every patient all options and services.

Participant 17: (5 months.; qualified; M): I think it's beneficial, especially when there's other patients around so you have that confidentiality...but if it's just the patient and the participant within the pharmacy at that point in time, I see no reason why you can't speak over the pharmacy area.... I would have happily just had a discussion over the counter rather than taking them into the

consultation room...Other staff tend to be doing their own jobs...Generally speaking staff see this all the time anyway and they get to know their patients well.

Participant 19 also explained that she does not offer private consultations to patients because she feels that communicating information at the dispensing desk is effective as long as no other patients can overhear the conversation. This participant also uses her own perceptions to drive judgments rather than offering patients a full range of options.

Participant 19: (3 yrs.; qualified; F): And there's other members of staff in the shop area doing the work that they, that they do so the reason why I stood there is because there was nobody else there. If there was any other, anybody else there in the shop area where I served the patient, I would ask them do you wanna go into the consultation room because it's a private thing. You know with medication, people, some people do like to talk about it in front of other people. Some people are fine with it.

Environment of privacy compared to other health care settings (Sub-category E3)

Participant 8 made a comparison between the privacy offered in pharmacies and the privacy offered in the physician's surgery. He said that pharmacy premises are more accessible, whereas the context of privacy in the physician's clinic is more private, quiet and comfortable. Moreover, in the pharmacy he experiences frequent interruptions by other staff during his consultations, and, due to this, he is unable to give his full attention to patients.

Participant 8: (7 yrs.; qualified; M): So as I was saying, if we were ...in the pharmacy and in that setting, I would probably have been disturbed at least two or three times in that conversation...

Participant 8 said that lack of full attention means that patients are sometimes reluctant to receive advice. Furthermore, he said that patients do not like being overheard by other people in the pharmacy. Offering private room is due to the participants' decision rather than making part of practice. However, patients can exhibit concern that confidentiality has been breached when other patients are present in the pharmacy, especially if conversations overheard by others in the pharmacy (Hattingh et al., 2015).

To summarise this theme, the majority of the participants in this study were confident dealing with patients with physical diseases but not with those who had mental illness. It became clear that some of the participants need more training about managing people with depression. Educating non-medical staff about mental illness helps to reduce the patient's feelings of stigma. Liekens et al., (2012) find that 57% of pharmacists report that the main barrier to depression care is a lack of education about mental illness. In order to educate patients about coping strategies, patients need more advice than the pharmacists provide. Limiting time hinders pharmacist when they try to satisfy the needs of patients (Barney et al., 2011).

The next section explores participants' engagement with patients.

5.2 Participants' Engagement with Patients

The participants identified their main role as advisors about medication; they said they are unwilling to give advice about matters that physicians deal with (Chong et al., 2013 C). However, they said that patients often lack an awareness of the extent to which the participants are familiar with giving advice about the drugs prescribed for mental illness, but participants were less eager to share information with patients (Olsson et al., 2014). Organisational barriers are another obstacle to effective communication with patients. Patients sometimes have their medicines changed without the pharmacist being aware. The participants also said that patients have access to various different pharmacies, and this means it is difficult to perform a follow-up.

(Chui and Stone, 2014) find that community pharmacists do not have access to the medical records of patients and so are unaware of the diagnoses made for patients. Moreover, the pharmacists expressed a lack of proper liaison with other health care professionals, which, they believe is essential for promoting the effectiveness of medication. The participants can also encounter many responsibilities and their therapeutic decisions often conflict with the advice given by other health care professionals (Cooper et al., 2009).



Figure 5.2: Elements contributing towards the participants' decisions for engagement with patients.

5.2.1 The Training Needed to Engage with Patients

Participants 1, 2, 3, 4, 6, 8, 9, 10, 11, 13, 14, 15, 17, 19, 21 and 22 made comments in this section. They exhibited limited relationships with patients. The participants all said they were less likely to hold two-way discussions with people prescribed new medication, one direction relationship and they did not give out advice about lifestyle.

All participants said that holding two-way discussions with patients intimidated some patients and they noted that people with depression are sensitive, and so

opening a consultation without using appropriate communication might trigger emotions. The participants said they experience less involvement with patients who have depression and they were concerned about consequences when they open discussions. Participant 4 used the term 'when I feel nervous' which indicates that she did not feel confident when interacting with some patients. Participant 6 said 'I'm going to struggle with making a decision' and Participant 8 shared the same concerns; 'there was a little bit of apprehension'.

Participant 8 said he is less decisive when interacting with patients and this means he engages with them less. This participant reported 'stepping back' from consultations and this indicates that he does not become actively involved with talking to patients. He said 'I don't have the tools' which shows that does not want to open up discussion with patients about medications, but just give one way advice about anti-depressants.

Participant 8: (7 yrs.; qualified; M): ...there was that little bit of apprehension. Am I going to get a positive or a negative reaction, so, again, that was probably sub-consciously in my Mind...but you're always stepping back and thinking, right, I don't want to go too far down this because I don't have the tools, I don't have the tools to counsel... it's outside the boundaries of medication supply.

Participant 9 revealed an awkward experience he had when he first began consultations with patients. Although he managed the situation, he said that his negative experience discouraged him from providing patient centred care. Participant 9 said that he is less confident when discussing lifestyle choices with patients. He said that opening up discussions was not in his agenda and he is more likely to give directive advice about medications without involving the patient in a mutual shared decision. Although involving patients in consultations can help to remove any uncertainties, this participant said he was less likely to engage in mutual shared decision making with patients.

Participant 9: (4 yrs.; qualified; M): Yes, it's, there's obviously finding it, they're going through a certain obstacle in their life so I don't try and talk about that...but try not to talk about it as much as possible.... because I don't really tend to go into that much detail with...I don't ask the patient why they're here as such because it could be a death, it could be anything ...to maybe lead onto further things.

Participant 10 said he is less likely to engage in a two-way consultation with patients. He said that during the initial stages of treatment, patients were not ready to involve themselves in a mutual discussion. However, he made this judgment using his own perceptions rather than giving patients' the opportunity to raise their needs.

Participant 10: (11 yrs.; qualified; M): ...but how do you change that? I mean sort of, you know, like I was saying, if you sort of put an animal in a cage it may heighten it you know? If I ask you a lot of personal questions, you're going to turn round and say well it's the first time we've met.

Participant 14 talked about the difficulties in engaging in two-way discussions about taking anti-depressants. He said he lacks confidence when advising patients about their lifestyles.

Participant 14: (3 yrs.; qualified; M): I didn't want to say don't take the medication because his lifestyle and the sleepless nights...I was giving information on how to take the medication, when to expect some results, and just when to see the doctor as well.

Participant 19 explained that she does not like offering consultations in which she explores patient values.

Participant 19: (3 yrs.; qualified; F): I mean it was a new experience for me because like I said, the time I've been qualified I've never really had the experience to actually have a full consultation with somebody about. most of the time I just ask them if they'd had it before their medication and most of the time they say yes they've been on it for x amount of yrs. so I think most of the time I know that they probably know more about the medicine than I know because they're the ones that are actually taking it.

Participant 19 was aware that giving out non-medical information would benefit patients, but she lacks the confidence to make her patients the centre of the consultation. Cates et al. (2005) find that pharmacists are more comfortable and confident when providing pharmaceutical services to people with depression than to those with cardio vascular illness. In this study, the authors suggest that the particular participants involved may have had better perceptions about providing care to people with depression. Nonetheless, the authors find that greater experience in practice correlates with a more positive attitude towards providing pharmaceutical care to those suffering from mental illness.

Role Perception (Sub-category F1).

Participants 1, 2, 8, 9, 10, 15, 19 and 21 did not perceive themselves in the extended role recommended to provide mutual sharing with patients. Participant 2 felt less self-efficacy when involving patients in discussions, but he said his role is to reinforce information to the patient about anti-depressants rather than to open up the discussion to include non-medication matters. He said that he did not have the skills to discuss a patient's social life or lifestyle.

Participant 2: (12 yrs.; qualified; M): what I know I can't do is, I'm not a psychologist. I'm not a counsellor. I'm not a doctor. I'm not necessarily able to influence those side of effects but I can influence on information about medication, about safety of it and about giving them a little bit more than they had already which means they're

likely to take it. If I'd say, just have a read of that leaflet, have a look at all of the side effects that are in there, they're not gonna take it.

Participant 11 said that he lacked proper training to be able to provide consultations that matched patient needs. He said he values communication skills during a consultation, but is less likely to be able to understand a patient's body language, and, therefore, less likely to pick up cues from patients. He said that patients have different beliefs about anti-depressants and he does not have the skills to encourage two ways conversations.

Participant 11: (18 yrs.; qualified; M): I'm not saying that Pharmacists aren't trained well enough but you need to have a degree of skill in some sort of psychology or sociology side of things to understand. You don't wanna be going into an area where very easily you could open a whole load of emotions.

To summarise this section, the participants need more education about communication to match their extended role in practice. Chong et al., (2013 C) use audio recordings to assess the pharmacist–standardised patient interaction. The authors conclude that pharmacists mainly provide advice about the safe and effective use of anti-depressants and do not have a full understanding of patients' medical conditions and other non-medical treatments. However, this practice is not congruent with how pharmacists see themselves, and this means that pharmacists face challenges when in practice. Noble et al. (2014) conclude that it is difficult for pharmacists to establish ways of communicating with patients. For example, patients do not understand why pharmacists ask them so many questions. Power (2010) argues that pharmacists lack a desire to carry out new responsibilities and are overly concerned about patients and other health care professionals.

The next section will explore the extent to which patients understand the role of the pharmacist.

5.2.2 The Lack of Patient Knowledge about the Role of the Pharmacist

Participants 1, 7, 10, 11, 15 and 20 said they do not believe that patients expect them to know much about mental health. They demonstrated that they are unable to open up to consultation, preferring to be directive in approach. The participants' approach is more likely towards advising about medication only, and less about lifestyle. One participant marked out clearly the differences between the physician's role and that of the pharmacist.

Participant 1 thought that people with depression have lower expectations about the knowledge of the pharmacist about mental illness. Patients view the pharmacists merely as a dispenser, with physicians being the experts on antidepressants. This lack of awareness about the pharmacist's role acts as a barrier to delivering information comfortably to patients. This implies that the participant does not take an active role with patients when they visit the pharmacy.

Participant 1: (5 yrs.; qualified; M): ...because I don't know whether that's, whether the patient sees the pharmacist as somebody who knows less. I think patients don't have that expectation, that a pharmacist will be a specialist mental health pharmacist or you know, can give them that expert advice regarding psychiatry. It is a very you know, specialist area.

Participant 7 said that patients visited the pharmacy when they wanted to collect their prescription, but they did not visit for additional support. This implies that patients view the pharmacist a dispenser and seller of medications and they are less aware that the pharmacist can promote adherence to medications. This lack of awareness about the extended role of the pharmacist works as a barrier to building the therapeutic relationship with patients.

Participant 7: (8 yrs.; qualified; M): Patients always, only, come in when they're ill, not always before they get ill...asking for advice.

Participant 11's comments supported those of Participant 10 in that patients are unlikely to be aware of the extended role of the participant. Nonetheless, this participant believes he can support patients by providing signposting to appropriate health care providers, self-help groups, and eliminating any concerns associated with anti-depressants.

Participant 11: (18 yrs; qualified; M): like the patient's saying he's got a good job, he's got a house, he's got no worries and then the doctors basically told him you're depressed and there's something wrong with you... So by the time they're coming to you, they've already made all their assumptions... Sometimes they may not be aware that holding a quick chat with a pharmacist may sort of alleviate some of these anxieties or worries.

Participant 20 said that people with depression are not keen to involve themselves with him because they perceive that the consultation 'MUR' is included in the role of physician rather than in the role of pharmacist. This results in patients not being receptive to consultations from pharmacists. However, although his patients have a low expectation of his abilities to undertake MUR, the pharmacist did not mention his patients' perceptions to the researcher after the pharmacist had conducted a MUR.

Participant 20: (3 yrs.; qualified; M): The patients don't expect the pharmacist to ask those personal kinds of questions... something called a Medicine Use Review... whenever we ask, sometimes, some of the patients to come in for a MUR, the first thing they'll answer is - oh it's a doctor's job - I've just had a consultation with the doctor, why do I need to chat with you? So that's why sometimes pharmacists tend not to go down that road.

To summarise this section, the patients' lack of awareness makes the participants less motivated to build therapeutic relationships with patients. It is possible that participants who do not have enough time to discuss matters with

patients build up a barrier that reduces patients' expectations. The expectations of patients are lower than the level of provision the pharmacists can offer, and some patients only visit the pharmacy to collect their medications without knowing that they can ask the pharmacist for a consultation. Therefore, patients are in a state of unawareness about the proper use of their medications, and they are not aware of the services pharmacists can offer in the pharmacy regarding consultation about medications (Olsson et al., 2014). Research carried out by Gidman et al. (2012) to assess public trust in community pharmacist services finds that patients felt that physicians had the authority to tell the pharmacist about medication decision.

5.2.3 Lack of Liaison with Other Health Care Professionals

A third of participants contributed in this section. Participants 2 and 11 said they do not have much contact with other health care professionals. They felt that collaboration with other physicians could improve therapeutic outcomes as well as providing opportunities to follow-up patients and enhance their quality of life. Participants 9, 11, 13, 14, 15 and 19 made comments about their relationships with other health care providers and noted that the professional authority of physicians influences the decisions they make. These participants said that their decisions sometimes clashed with those of the physicians but that ethical responsibility relinquishes to the physicians.

Participant 11 made comments about collaboration with other health care professionals and noted that he does not get regular interaction with other health care professionals and this makes therapeutic management less successful. He said that physicians are less likely to signpost patients to their pharmacists, and, thus, patients are less likely to expect the pharmacist's support. He said that community pharmacists have the knowledge to review the patient medication and enhance patient well-being.

Participant 11: (18 yrs.; qualified; M): There needs to be some sort of triage sort of thing with doctors and, you know, pharmacists, and, you

know, psychotherapists, and things like that, because it's very easy for patients to leave a GP surgery and not even go to the pharmacy.

Hierarchy among health care professionals (Sub-category I1)

Participants 1, 2, 8, 9, 10, 13 15, 19 and 21 made comments that their role was limited to dispensing and informing rather than exploring patient needs. Participant 9's agenda was to advise patients about the safety of medications, rather than conduct shared consultations with patients. In agreement, Participant 13 showed good knowledge of anti-depressants but said he has little authority to liaise with patients' about their treatments and this makes him feel less responsible for the treatments he hands out.

Participant 13: (5 months; qualified; M): ...but whether or not he is happy to be on this drug because if you're not happy, doctors given it to you, it's a difficult situation and to feel that you have take it but really it's up to you if you want to take it or not.

Participant 15 is less likely to be pro-active with patients when he is rejected physicians. Participant 15 said that patients are less likely to adhere to his advice when it conflicted with the physician's advice. This implies that patients place more trust in their physicians even when the physician has not involved the patient in their treatment decision. This situation makes the participant less likely to be pro-active when dealing with patients.

Participant 15: (3 yrs.; qualified; M): ... This is my own experience in the Community that is and even when they do, they don't understand well how it works or they just know that they have to take it. They view it in the sense that, they take medicine based on trust in that the doctor has said I (patients) have depression. He (physician) says I (patient) need to take this medicine to treat my depression therefore, I (patient) must take the medication. A lot of it is based on trust.

To summarise this section, therapeutic collaboration is good practice for making patients the centre of the care. This would enable participants to monitor medications and follow-up with patients. Furthermore, collaboration provides motivation for the participants to contact other health care providers when patients experience health issues. The current lack of collaboration with other health care professionals results in participants relinquishing their therapeutic responsibility when their decisions conflict with those of other health care professionals. Pharmacists feel subordinated to the physicians' decisions and they sometimes encounter conflict with physicians when they notice interactions between two medications, and this leads to ethical problems (Cooper et al., 2009).

Other health care professionals influence the decisions of the participants who are then less likely to decide upon therapeutic outcome. Physicians perform clinical assessments and make therapeutic decisions, and so they have more authority to take decisions about patients' health conditions (Harding and Taylor, 2002). Conflicts between physicians and pharmacists have an effect on professional performance and pharmacists feel they have little power to make decisions, so instead they take orders from their physicians. This hierarchy creates a dilemma between pharmacists and physicians over some decisions (Kälvemark et al., 2004).

5.2.4 Organisational Barriers

The participants were optimistic to have more information about the backgrounds of patients. Participants 1, 2, 4, 7, 10, 11, 14, 15, 19 and 22 made comments that health care systems are not linked to pharmacies in the same way they are linked up in other health care settings. The lack of adequate software to maintain digital contact with other health care professionals acts as a barrier to the participants' knowledge of the patients' health issues, and this means that pharmacists are not always able to provide follow-ups for patients. Participant 2 raised concerns about a lack of information about the medical backgrounds of patients. Knowing the medical background of a patient can help the pharmacist to communicate therapeutic information to the patient properly.

However, this participant's approach was to give directive advice without knowing the full background of a patient's health needs.

Participant 2: (12 yrs.; qualified; M): ...and I don't know enough about you as a person, your personal situation... so I think this is just some of the information you'd have probably already got from the doctor.

Participant 15's comments supported those of Participant 2. He said that the lack of a web-based system to connect to other health care professionals could act as a barrier to expanding discussions. He said that the causes of depression might result from physical and/or mental disorders, and so to involve the patient in care, the participant needs to know more about the patient's medical history. He said that trying to explore medicines with patients without knowing their medical history is difficult.

Participant 15: (3 yrs.; qualified; M): ...because obviously whatever that depressed episode may be...for starters I never even confirmed if it was a depressive episode or whether or not it's something that's been building ...it could be, I don't know, it could be seasonal affective disorder.

Participants 22 said that organisational barriers proved to be a problem when she worked in different pharmacies, and these barriers decreased her opportunities to form friendly relationships with patients.

Participant 22: (10 yrs.; qualified; F): ... obviously whatever that depressed episode may be; for starters I never even confirmed if it was a depressive episode or whether or not it's something that's been building and he doesn't know whether or not it's just something that's just happened. It could be, I don't know it could be seasonal affective disorder. It could be something that's just happened out of the blue and he can't explain it.

Participant 22 said that developing relationships with patients is a key factor for communicating comfortably. She indicated it was routine for her to try to develop communications with patients.

To summarise this section, involving the participants in interdisciplinary teams would enhance their engagement with people with depression. In accordance, Chong et al. (2013 b) find that implementing web based networks across different clinical settings and including pharmacies is important to facilitate the accessibility of medical histories and, thus, improve communication between different health care providers. A lack of information about the history of patients acts as an organisational barrier for pharmacists. Chui and Stone (2014) find that community pharmacists do not have access to the medical records of patients and so are unaware of the diagnoses made for patients.

5.3 Tailoring the Consultation

The content of this theme discusses the skills required to deliver effective consultations. This theme deals with the behaviour of the participants when intend to negotiate patients' agenda (Pharmacy Guild of Australia, 2010). Moreover, the participants perceived the importance of gathering information about medication history and current medication to assess the backgrounds of patients. Giving out information is included in this theme. The participants' opinion is that it is essential to provide understandable advice to support patient adherence to their medications. NICE states that pharmacists must undertake medication review for people of different ages. Professionals must structure treatment to individuals with the objective of reaching agreement with patients about treatments, reducing medicine related problems, and optimising the impact of medications (NICE, 2015).

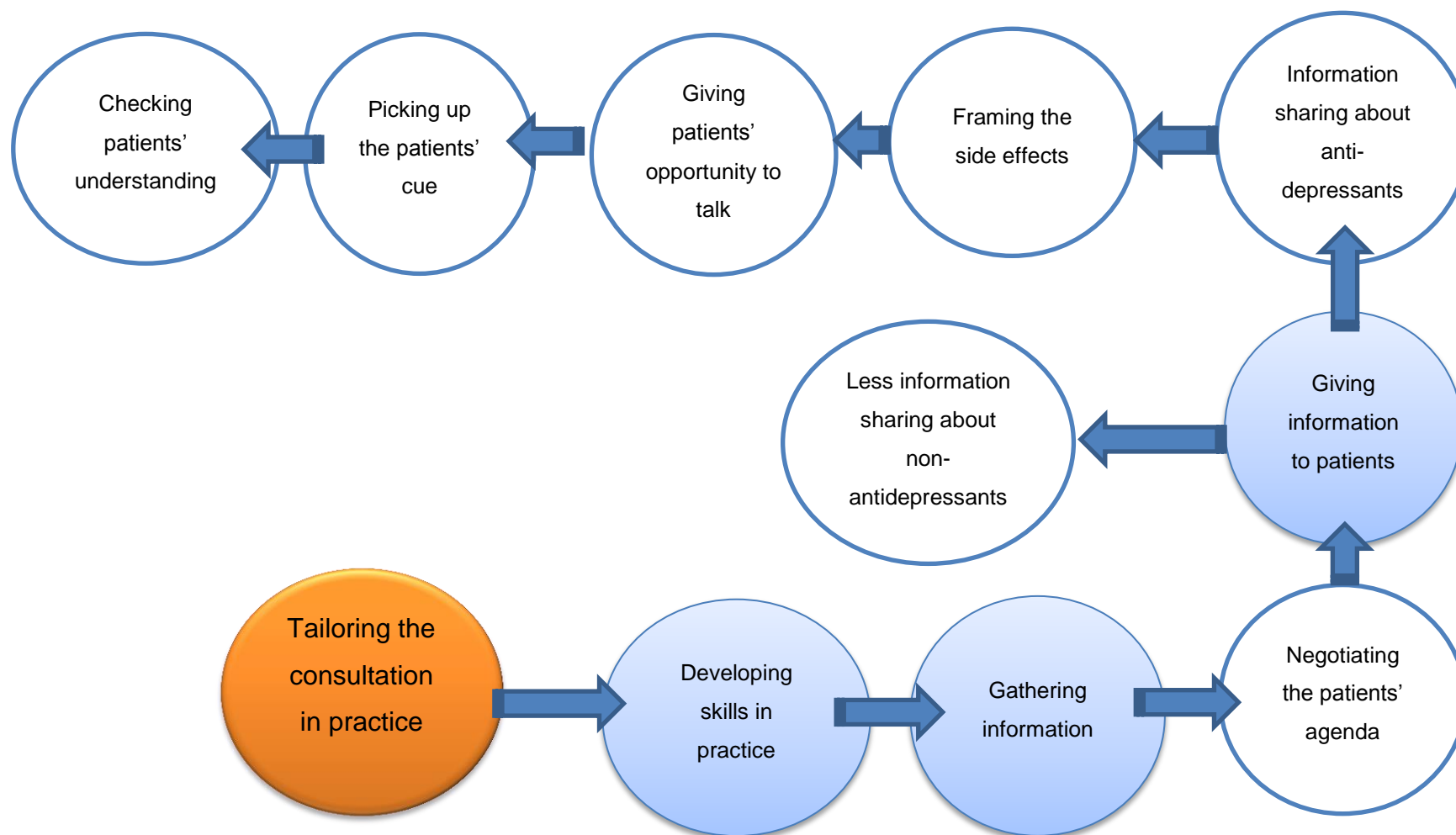


Figure 5.3: Tailoring the consultation to the patients' needs'.

5.3.1 Developing Skills in Practice

This section outlines the experiences of the participants when they meet with patients and use their skills in daily practice. Participants 2, 3, 8, 11, 14, 15 and 21 took part in this section. They talked about building-up skills in practice unconsciously, but these skills play a vital part in helping participants to communicate with patients.

Participant 8 felt that his skills have become routine and he does not feel he actively uses his skills. This implies that the participant does not think about how to use communication skills and is only aware of using skills when an incident occurs to make him reflect on the interaction, for example, a training session or an awkward consultation.

Participant 8: (7 yrs.; qualified; M): ... Okay initially my feelings were based on the nature of the medication so once I'd seen the patient had been dispensed Sertraline, again maybe not consciously, sub-consciously there was right this is something important, this is something that I will have to kind of cater for with a little bit of tact so, that kind of choice of consultation room and privacy was the first thing that came to Mind. I think right this is probably not a conversation I would have on this counter, let's move it to a private setting.

Furthermore, Participant 11 used the term 'libido' rather than 'sexual dysfunction' when talking about a patient when he picked-up on cues from the patient about the side effects of anti-depressants. The participant said patients make him conscious about using his communication skills, rather than being something he did consciously and regularly.

Participant 11: (18 yrs.; qualified; M): 'I think I felt, I felt that from your reaction as well. I think I needed to sort of slip that in somewhere because there's a tendency of being quite robotic towards you know,

counselling and feeding patients with information because you can have a step and go right that's it, that's all that, go away, thank you.

Nonetheless, Participant 21 said she is less likely to build relationships with patients. The nature of locum pharmacy hinders the participants to contact with the same patients, which possibly she could not have the opportunity to reflect on her skills in the practice. This implies that the working in different pharmacies less encourages the participants to create professional relationship with patients.

Participant 21: (2 yrs.; qualified; F): I think that's the; I'd never actually thought about that. I've never actually thought about the future (laughing) about you know cus it's an ongoing treatment obviously so I said so myself it can take you know months for it to work or months for it you know last of the therapy so but I can see why perhaps I didn't think of those because my actual role is like a locum Pharmacist so what I do is I work in one place. I may not be there for another five weeks or something or never ever and so I don't actually think about the ongoing relationship with a patient necessarily.

To summarise this section, the participants developed skills during practice, but only demonstrated certain skills occasionally. Participants said they used a different approach for physical and mental health conditions, and this enables them to integrate their skills to every individual. Participants practiced their skills without being aware of using them. Therefore, unconscious competence becomes 'second nature' and exhibits itself when there is a need to deliver information to patients (Chapman, 2015).

5.3.2 Initiating the Session

Half of Participants 1, 4, 7, 10, 11, 14, 15, 17, 18, 19, 20 and 21 said they believe in the importance of building an initial rapport with patients. This initial communication enables the participants to offer a consultation and it helps the

participants to set their own agenda. Moreover, the participants felt that it is at this stage of interaction when they find out physicians provide the right information. This time helps the participants to take the patient and physician agenda into account. The participants who made comments gathered information about anti-depressants in order to enhance the patients' expectations of their pharmacies and the therapies (Grimes and Barnette, 2014). The participants said they are more likely to advise about the safety of medications, which they felt was essential, in order to show their competence, but they are less likely to advise about lifestyle, because they felt this was within the remit of physicians.

Negotiating an Agenda (Sub-category K1).

The majority of the participants saw the importance of good initial relationships with patients. Participant 1 said it is his responsibility to find out about the patient's background because this knowledge can aid the patient's experience with anti-depressants. This participant used the term '*expert advice*' and explained that he has three yrs.' experience dealing with mental health medication.

Participant 1: (5 yrs.; qualified; M): Shall we have a, you know, talk about your medication? Is there any expert advice that you want about your medication? Then again any questions, specific questions to treatment or illness that the patient might have.

He said that building an initial rapport encourages patients to form their own agenda and decide what they would like to communicate during the interaction. The participant said this helps him to gather information about the patient's ideas and concerns.

Participant 8: (7 yrs.; qualified; M): ...then again any questions, specific questions to treatment or illness that the patient might have.

Participant 8 said there might be sensitive information that patients might want to discuss and putting patients at ease might encourage them to raise hidden concerns. The participant felt this communication provides an opportunity to share information with patients. Participant 9 believes that the physicians do not have sufficient time to give advice about adherence to anti-depressants.

Participant 9: (4 yrs.; qualified; M): ... well my feeling was that obviously the patient hasn't had it before, I need to go through in a lot of detail because I find that doctors do miss a lot of information off unfortunately. They don't have time for it so they've got like 8-10 minute consultation periods.

Participant 9 felt that his role is to explore the patients' agenda for structuring the consultation. This enabled the pharmacists to assess the information tailored to the patients. Likewise, participant 20 said that they hoped to assess the patient's views about depression and their beliefs about anti-depressants, and this discussion gives patients the chance to discuss issues with the provider, and facilitates the communication of important information.

Participant 20: (3 yrs.; qualified; M): ...the patient said to me, I mean, like my first question was to him is, what's your understanding of the illness and of the medication?

To summarise this section, building an initial rapport with patients encourages the participant to understand the patient's agenda and enhances the patient's expectations. It also helps participants to structure the consultation. Grimes and Barnett (2014) find that pharmacists usually ask patients the reasons for visiting the pharmacy not only to establish initial rapport but to give the pharmacist opportunity to tailor information to the patient and decide the structure of the consultation. Guirguis (2011) notes how three main questions (What are you using this medication for? What did you see the physician for today? This medication has several uses, what are you treating?). These questions can open-up the consultation, and the pharmacist values the positive outcomes of

these questions. Guirguis notes that these questions enable patients to provide the pharmacist with up-to-date information about their medical histories.

5.3.3 Giving Information to Patients

This section discusses the quality of information given to patients. In practice, participants form opinions about how to communicate and frame information about the side effects of drugs. Some participants do not wish to overload patients with too much information, and others believe that giving patients too much information about side effects might scare the patient. The participants in this study were willing to provide information that enhanced medicine adherence. The participants valued their skills for giving the patients opportunity to talk because this enables them to be able to listen actively to patients and pick up patient cues. The outcome of communicating effectively with patients is building positive relationships with them (Black et al., 2009). However, communication between professional and patient was a key factor to increase adherence to anti-depressants. The majority of physicians reported that they informed patients to continue anti-depressants (Bull et al., 2002).

Information sharing about anti-depressants (Sub-category L1)

Participant 1 said that patients prefer to get advice about their medicines rather than mention non-medication treatments to for promoting patients. The participant said that this decision resulted from his experience working in a 'mental illness setting'. He said patients were more willing to receive information about the effects and safety of medications than lifestyle support.

Participant 1: (5 yrs.; qualified; M): my background is mental health and I've worked quite a lot, extensively, with, you know, depressed patients. Which is, I think the expectations of patients from day one? I see you know in mental health, it's one of them areas where patients want clarity. Because it's important obviously with this type

of treatment to make sure, the patients aware that for the first days it's gonna because initial worsening.

Participant 2 said he was knowledgeable about anti-depressants and talked about the 'terms of the pharmacy and the pharmacist'. This indicates that he has good knowledge of medication related information and this knowledge would probably satisfy the needs of patients concerning anti-depressants. This participant's knowledge also covered evidence-based information, which supported his provision to patients.

Participant 2: (12 yrs.; qualified; M): I know the kind of information that I want to give to a patient and I just need them to take that on board...but in terms of the Pharmacy and the Pharmacist in getting that medication to the patient...I know what I know from the medication and from the research and the information.

Participant 6, (an MPharm Student), said he elicits information about patient self-harm. In this research, he was the only participant who involved himself in obtaining sensitive information about suicidal intentions.

Participant 6: (MPharm Student; M): Yes it's I've just studied the NICE guidelines and it's like right at the front is the suicidal tendency part.

Participant 6 refers to standard guidelines saying that health care providers should ask patients if they intend to harm themselves. Participant 9 said that anti-depressants might take few weeks to reach full therapeutic effect, and noted that the non-adherence rate was high at this stage. This participant said that he always encouraged patients to continue adherence in order to reduce the symptoms of depression and avoid withdrawal symptoms when they stopped taking their medication. This participant's phrase '*I always*' could indicate that he has experience with patients who are non-adherent in the early stages of receiving anti-depressant medication.

Participant 9: (4 yrs.; qualified; M): I always tend to go through in a little bit more detail and spend with the patient at least about two or three minutes just going through what they've got, you know what they can actually expect the side effects usually with something like this it's, you do get some unwanted side effects but people do get alarmed and go, phew I aint taking them.

Participant 8 said his intention was to explain the most frequent side-effects to patients because this enhances adherence to medications. He said that during a first meeting his motivation is to provide information but not to scare the patient with negative information.

Participant 8: (7 yrs.; qualified; M): ... I mean with regards to sort of side effects, could well have gone through some of the more sort of serious side effects, which you'll find, on the label if you open it. You'll find loads in there. That would probably put them off straight away, so just more or less the main ones what.

Participant 8 said that patient information leaflets could reduce adherence to anti-depressants. Therefore, his motivation was to put patient at ease when reporting the side effects. Participant 15 said that training about the safety of medications is required in order to deliver information that matches patient needs. The participants in this study felt that information about mental illness differs from information about physical diseases, and that the negative side effects of anti-depressants can discourage patients from adhering to their medications.

Participant 15: (3 yrs.; qualified; M):... having the right amount of information and obviously, I think the most important thing, I think I don't want to labour the point but if I place depression on the same category as diabetes, asthma, gout for goodness sake, all these type of things, if I put it on the same level as that then the patient maybe

will register that this is just any other illness this is. There's no need for me to think that other people will think bad about me.

Participant 6 said that the positive framing of side-effects could improve the behaviour of patients towards their medication. Participant 6 said he is more willing to ask patients if they experience the need to self-harm and said that he does not use jargon in case this scares the patient.

Participant 6: (MPharm Student; M): ...without using the word suicide...and then you'll start to notice this effect in a couple of weeks' time...and then the full effects will be four to six weeks.

To summarise this section, the participants were aware of anti-depressants and the need to enhance patients' well-being. Their knowledge covers different specialities and this increases the potential for individual responsibilities. However the participants less able to provide advice which enhance the quality of life, possibly lack engagement with patients make the participants more medicine focus. In accordance with, a study by Chong et al. (2013 C) uses audio recordings to assess pharmacist–standardised patient interaction. The authors conclude that pharmacists mainly provide advice about the safe and effective use of anti-depressants, rather than trying to understand the patients' medical conditions or give out other non-medication advice for depression. However, Winstanley (2011) recommends that pharmacists take an overview of a patient's history and this includes personal information, lifestyle, including home circumstances, relationships with friends, and beliefs about long-term health issues.

Giving patients' opportunity to talk (Sub-category L2)

Participants 3, 8, 11, 14, 17, 18 and 21 said that giving patients the opportunity to talk enables the participants to understand patients.

Participant 8 said that he usually encourages patients to talk. He said that listening to patients helps build relationships; he values the chance to give patients the opportunity to speak because this results in enhanced satisfaction when communicating with patients.

Participant 8: (33 yrs.; qualified; M): ...the patient was very forthcoming in sort of the discussion. I didn't real have to kind of pick at anything or kind of lead in that sense. I always give the patient the option, which was good, but I mean that's not to say that would be the case every time.

Participant 18 said that patients can be passive and it is his responsibility to take pro-active behaviour and encourage patients to talk. This happens when with open questions that encourage patients to tell their stories.

Participant 18: (3 yrs.; qualified; F): ...regarding these open question and you should give chance for the patient to talk about it first and get all the information out of him but once you go there, out there in the Pharmacy you start just like, you know it's; some patient like to talk about things or they sometimes talk but most of them they don't like to talk about it so you start.

Chong et al. (2014) assess the characteristic communication between pharmacist-patient during the consultation. Pharmacists showed fewer instances of inquiring about the opinions of patients and open questioning; these were important skills to elicit patient concern and feeling of partnership relationship.

Picking up the patients' cues (Sub-category L3)

Participants 2, 14, and 15 perceived the importance of picking the verbal and nonverbal behaviour of patients during the consultation.

Participants 2 said that reflecting on the responses of patients was his 'style' when communicating with patients but he changes his approach if the patient does not show any cues so he can meet the needs of patients.

Participant 2: (12 yrs.; qualified; M): ... some people you can have a bit more of an in-depth conversation, some people you know really want somebody to talk to and really want to get a bit more information or some help and so you have to just try and match that to the individual patient and what you get back from them and what they appear to want. It might not be what they really want or it might not be what they really need but you can at least meet them half way with it.

In accordance with Participant 2, Participant 14 said that he uses communication not only for giving information but to gain the patient's attention; this encourage patient to raise their hidden concerns.

Participant 14: (3 yrs.; qualified; M): ...what he's saying so not to feel too robotic like I'm trying to get something out of him but more that I'm trying to help him by catering my questions towards what he's saying.

Checking patients' understanding (Sub category L4)

Participants 2, 11, 16 and 19 said that they took a more explicit approach when asking patients if they understood information. Participant 19 said that closed questions do not work to help a patient indicate their understanding, but that patients were unlikely to hide misunderstandings. However, she said that she used closed questions to avoid upsetting patients. She avoided using 'telling back' because some patients perceive this as a test to see if they have understood information.

Participant 19: (3 yrs.; qualified; F): During the consultation I asked the patient do you understand what I mean because some people don't like to you know, ask questions, some people don't like to question. You know if they don't understand something they're a bit scared to say I didn't understand that so that's why I thought I'd put the first, make the first move on you know explain something and then say do you understand that?

Less information sharing about social treatments (Sub-category L5)

Half of the participants made comments in this section. Participant 14 said that the role of the physician is to provide information about lifestyle but he is less likely to check his patients' awareness of non-medical information.

Participant 14 (14 yrs.; qualified; M): I didn't mention lifestyle but I probably could have mentioned a bit more because with depression going to gym, having healthy balanced diet, that does really help as well and it's focussing on your lifestyle. What we do is relay the information to the doctor and help patients on a medication level and a lifestyle level.

Participant 19 felt that her patients are less interested in information about anti-depressants or lifestyle, but patients are aware of their treatment and so are less likely to ask for more information. However, this comment might reflect the individual perceptions of Participant 19 rather than actual patient preferences.

Participant 19: (3 yrs.; qualified; F): I think, most of the time, I know that they probably know more about the medicine than I know because they're the ones that are actually taking it.

Participant 21 indicated that she is less decisive when giving out information to enhance her patients' well-being for example the participant, aware of the information about lifestyle.

Participant 21: (2 yrs.; qualified; F): I didn't know whether someone might be, you know, not wanting me to ask personal questions about their lifestyle and stuff, even though it might have helped, in hindsight.

Participant 21 perceives that patients are less likely to be responsive to information about things other than anti-depressants. The pharmacist made judgments based on his perception that patients were more willing to receive advice about anti-depressants than about lifestyle. Patients possibly have different views and so pharmacists should be non-judgmental (Grimes and Barnette, 2014).

To summarise this theme, the participants valued the skills for communicating and giving advice to patients. The participants' advice is mostly to maximise the efficacy and safety but they are less willing to support patients with information about lifestyle. In contrast, pharmacists spent time giving advice and but listened less to the patients, and patients took a less active role in making choices about their treatments (Chong et al., 2014). The next theme will illustrate the staging of advice to patients

5.4 Staging Advice to Patients

This theme illustrates the quality and quantity of information giving to patients. The participants were more paternalistic at the early stage of treatment. This kind of paternalistic approach is due to various reasons. An eagerness to establish an agenda early on encourages participants to be passive and closes down opportunities for patients. This approach raises issues about the quality of information exchanged between the participants and the patients (Anderson and Roy, 2013). Building relationships is the second category in this theme; the participants were more likely to build trust and respect with patients over time

and this facilitates the provision of the service. The participants appreciated the verbal and non-verbal cues given by patients and positive communication with patients (Riley et al., 2013). This section will also cover the opinions of the participants when they offer patient advice (Guerreiro et al., 2010) and have a second meeting with patients during which they are more able to provide non-medical information (Wells et al., 2014).

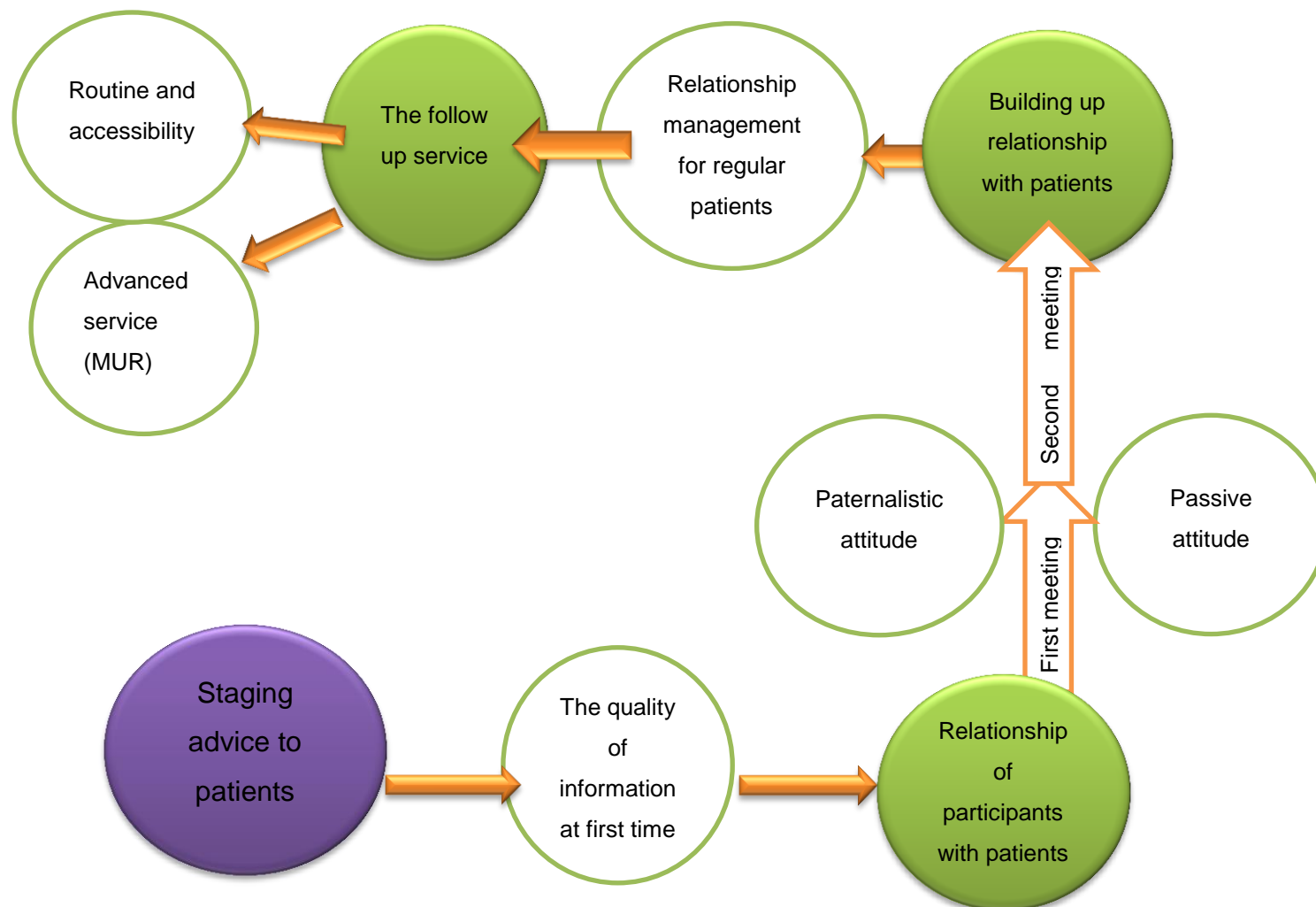


Figure 5.4: Participants dividing advice and information, which suits the patients' health status

5.4.1 The Quality of Information at First-Time Consultation

Participants 1, 3, 4, 7, 8, 9, 10, 11, 15 and 17 tended to focus on giving out medication related information rather than information about lifestyle. The participants perceived that patients are not willing to listen to information about lifestyle and are less likely to remember this information.

Participant 1 thought that the cognition of patients is more likely to be affected by the symptoms of depression and that patients are less likely to remember all the information they are given. He said that giving the right amount of information helps patients understand their instructions.

Participant 1: (5 yrs.; qualified; M): I know Jim might not take on most of the stuff that I said and that's why I tried, you know have you understood what I'm saying. If I had, I'd usually have literature to give as well you know like leaflets and say look this is the websites. I'd write them down, look try you're Mind, and try depression, good support groups.

Participant 9 said that he frames his explanations based on the 'positive, negative, positive' model, which balances between the negative and positive actions of anti-depressants. He uses this explanation to enhance patient perceptions about the effectiveness of anti-depressants.

Participant 9: (4yrs.; qualified; F): I tend to do that sort of thinking yes, look this is a positive, the negative but here is a positive. You know if you do take it, it will go hence why we draw the charts. You'll fall down but then you will peak up and it will kind of level off after a while which is the case.

Participant 3 said that giving out information about lifestyle does not help patients, especially during a first-time meeting. She said that patients might be

confused by their diagnoses, and giving out information about non-medical information makes patients less willing to accept the information.

Participant 3: (15 yrs.; qualified; F): ...if somebody's depressed and really depressed, they're not going to start playing squash until they're on their way back up. What planet are you on?

This participant said that he reflects on the responses of patients during the consultation and that he picks up cues from patients, reading these as indicators of satisfaction or that patients are not ready to receive more information.

Participant 11: (18 yrs; qualified; M): ...yes, but at the same time you've got to look at how much information you're giving to the patient as well, and I felt maybe at that point we were trying to possibly terminate the consultation at some point...

To summarise this section, the participants appear to prioritise information that relates to the safety and efficacy of anti-depressants over lifestyle and other non-medication based information. In accordance with, Crump, et al. (2011) find that community pharmacists tailor information so as not to overwhelm patients and they find that information that is tailored to the needs of patients enables patients to absorb and process information. However, Salter et al. (2007) find that pharmacists do not consider the knowledge and competence of patients and tend to deliver information not tailored to the needs of patients; this behaviour makes the patient think that the knowledge or competence of the pharmacist is limited.

The next section will explain the role of the pharmacist-patient relationship when advising patients.

5.4.2 Relationships with Patients during Consultation

All participants, except Participants 1, 2, 3, 7, 15, 11, 14, 17, 19 and 21 were more likely to be directive when advising patients about their anti-depressants, and they were likely to form an agenda in advance of their interaction with patients, which they believed matched the patients' needs. Furthermore, they felt that patients are unwilling to discuss issues concerning lifestyles because this is something they do with their physicians.

Paternalistic attitude (Sub-category N1)

The extract below quotes Participant 2. His agenda is not to decide upon mutual communication, but to set an agenda for communication in advance.

Participant 2: (12 yrs.; qualified; M): ...am probably quite closed in terms of the questioning... yes I freely admit that I'll rail road patients into stuff...the goal was probably quite narrow... I don't necessarily, that is more what is gonna set the tone of the consultation and I will lead it in the direction that I wanna lead it with that particular person more than actually having, like you say, a way of getting a more open consultation with every patient.

Participant 2 said that he often decides on the advice he gives about the effectiveness and safety of medications in advance and avoids talking about non-medication issues with a patient. Therefore, this participant makes assumptions about the values of the patients.

Participant 3: (15 yrs.; qualified; F): I think I waffled more than I would because I didn't, I didn't act well, well it's not about acting but you know in a normal Pharmacy what I would have tended to have done it would have come to a more natural close quicker...I covered what I wanted to cover... But it wasn't opened up either

Moreover, participant 3 felt she was less likely to listen to patients' preferences. This implies that this participant is less willing to encourage mutual discussions with patients. Nonetheless, her approach takes authority away from patients, and so her patients become passive. Furthermore, Participant 15 said that his directive style of consultation results from his perception of being a professional who knows more about essential medicines than he knows about his patients.

Participant 15: (3 yrs.; qualified; M): I think I focussed a little bit too much on the medication, the treatment, the course rather than may be focussing on some of the grey areas of the conversation. Again, that might be reticence in terms of my own personality or it may be something to do with the fact that well I'm a Pharmacist and that there's a certain degree of professionalism that prevents you from being a little bit more probing. It might be one of the two.

Participant 15 said that he has had vast experience in practice with patients, but it became clear that this encourages the participant to make decisions on behalf of patient. It might be that the participant thinks patients are less likely to be able to make decisions, especially in the early stages of their treatment, and, therefore, he takes responsibility for talking about treatments. However, this approach does not consider the patient's individual needs. The participant in this study showed a paternalistic attitude during the consultation. Nonetheless, Riley et al. (2013) assess the cues and concerns of patients by comparing their dealings with their GPs, pharmacists and nurses. This study finds that pharmacists respond positively to the cues of patients and they are able to reassure patients and acknowledge cues concerning lifestyle and medication

Passive behaviour of the participants (Sub-category N2)

Participant 2 is less likely to use pro-active behaviour to decide if a patient is able to take their anti-depressants. This participant felt that patients already have agendas before they visit their health care professionals and that patients do not always communicate these agendas to the participant. These

perceptions mean that the participant is less likely to share information with patients.

Participant 2: (12 yrs.; qualified; M): I don't probably know whether you would take the tablets or not ...they know what their situation is up to that point. They know they went to see the doctor. They might not have gone to see the doctor about depression. They might have gone because they couldn't sleep particularly.

Participant 15 is less interested in providing advice about lifestyle and enhancing social relationships. This participant made judgments that young people can usually manage themselves and, as a person, said he is more prone to opening up consultations with the elderly, mainly because he thinks that the elderly lifestyle is more complex and they receive less support from other relatives. This participant said he is more passive with some patients than with others.

Participant 15: (3 yrs.; qualified; M): Yes, I think that is one thing that obviously, I think that's a blind spot. I don't think I mentioned that but I think looking at the age of the patient like for example if this person was maybe, maybe I don't maybe 10/15 yrs. older, they might have triggered something like maybe 20 yrs. older like in their 70s or 80s, loneliness in the elderly population. With this gentleman (standardised patient), I wouldn't consider him to be elderly.

Moreover, participant 20 said that physicians advise patients about their medication and other health related treatment, and so he is not pro-active and assertive when dealing with patients. He said 'I don't know whether he did or not' and this indicates that the participant is less responsible for his patients' treatment. Here, the participant makes assumptions about the role of the physician, the treatment prescribed, and his interactions with patients.

Participant 20: (3 yrs.; qualified; M): I'm sure the doctor would have listened to any of his problems and then because he must have explained some information to him, but I don't think that much in depth. I don't know whether he did or not. Because I'm assuming the doctors must have, they probably thought all the information that they needed, they've got it from the doctors...

To summarise this section, the participants in this study were reluctant to build up relationships with patients and were more likely to be directive when communicating with patients. The participants were less likely to offer opportunities for patients to talk during a consultation. This resulted in the patients feeling less empowered about their medications. Chong et al. (2014) note that pharmacists spend time giving advice to patients but less time listening to patients, and those patients take a less active role in being involved in and making choices about their treatments. Furthermore, Assa-Eley and Kimberlin (2005) find that 43% of patients agree that pharmacists are passive when they are dispensing prescriptions, while 22% of patients state that pharmacists always ask them if they have had any medical related issues between when they last collected their prescription and the current time.

Building relationships with patients (Sub-category N3).

Participants 3, 7, 9, 15 and 17 said that building relationships with patients is important for communicating information. The participants recognised that people with depression might perceive stigma and confusion, and that empathy may enhance their relationship with the patients. Participant 4 said that doing this shows empathy with patients and helps to form friendships that build trust. This could imply that relationships between participants and patients may not only be therapeutic but also social.

Participant 4: (MPharm Student; F): ...not to upset them... I'm quite friendly with them. You don't want people to think that you think anything negative.

Participant 11 said that building good relationships, especially when trying to eliminate patient concerns about side effects, is important because the successful engagement with patients is an indication of positive communication.

Participant 11: (18 yrs.; qualified; M): I seem to be seeing those. There was quite a good engagement. I seemed to have his attention you know, he seemed to be quite compliant and willing to, but I felt there was sort of a good communication there and asking me questions after, and I also would have felt that there's a good chance he would have called me.

Participant 11 felt that establishing good relationships encourages patients to visit the pharmacy to help. Likewise, Participant 3 gives patients the opportunity to make decisions about their treatments rather than giving out orders to patients.

Participant 3: (15 yrs.; qualified; F): ... and I wanted to make sure that they left; I really wanted to make sure the patient felt this is their choice. I am not telling you. You must take (sigh) but at the same time, I want you to encourage it to give it a go. And I still think I would like to say you don't have to share because I actually think that's quite intimidating.

Participant 3's intentions were to empower patients by respecting their legitimacy and avoiding a non-judgemental manner. This might make patients feel that they are the owners of their treatment and appreciate interaction with the pharmacist. Another Participant 11 said that the severity of a medical condition was not only the reason why the participant should prioritise patient care; he said he did this to take responsibility for patients. The participant felt that the legitimacy of patients has to be respected, and these views might reflect on the participant's actual role in helping patients.

Participant 11: (18 yrs.; qualified; M): You've got to understand, no matter whether you have ...a slight issue with a headache or whatever, you've got to treat everything within the same level.

In agreement, participant 9 said that physicians lack time to give advice about anti-depressants to patients. He felt that it his responsibility to give more attention to patients, and educate patients about their medication. This possibly creates good opportunity to enhance the patient's trust in his competence.

Participant 9: (28 yrs.; qualified; M): ...the second one kind of fills that gap up, and makes sure there is no barrier between the patient themselves and the healthcare professional.

Relationship management for regular patients (Sub category N 4)

Participants 1, 2, 3, 4, 7, 8, 10, 11, 14, 17 and 22 felt comfortable holding discussions with people who regular come into the pharmacy. This regularity helps to build up a good relationship for both the participants and patients.

Participant 1 said that he is less likely to talk about the more severe symptoms of depression with patients, for example suicidal thoughts, during a first meeting, but he might mention these during the second visit.

Participant 1: (5 yrs.; qualified; M): I would just have the same conversation you know, oh okay, oh Jim you've had some surgery, you know you get onto a level with them, a rapport with the patient and you can then delve more deeper into the personal type of issues whereas if it's a one off prescription of a person who's just come and presented and you've not even got them on your record and it's the first time the patients come to your Pharmacy.

Participant 1 said that dealing with patients regularly enhances trust for the patients and the provider. In addition, participant 2 said that patients might not involve themselves in the discussion unless they have high expectations of the

provider, and that they are more likely to raise their concerns and preferences when they have a good relationship with the participant.

Participant 2: (12 yrs.; qualified; M): You can get a lot of things, particularly the patients that I do see on a more regular basis.

Participant 3 noted that patients are more willing to chat about their feelings on their second visit. Participant 3 said that he is more likely to advise about well-being after the patient is better and, in this way, the participant is able to enhance the promotion of health care and signpost to medical charities were applicable to facilitate self-management. Participant 22 said that stigma makes patients less willing to receive information about lifestyle, but that enhanced relationships with patients facilitates her ability to give advice about health and well-being. The participants said they value the role of building relationships for communicating information because it encourages participants to open-up during the consultation. Building relationships enables the participants to pick up patients' cues and to communicate information they are unable to impart without establishing a relationship. Crump et al. (2011) believe that pharmacists feel it is essential to develop trust and be empathetic with people with depression. They find that building good relationships with patients is a basic behaviour for delivering successful care Grimes and Barnette (2014) explain that pharmacists should be able to understand their patients' feelings and situations and that depression exacerbates due to inconsistent relationships. They also note that pharmacists should exhibit empathy when communicating with patients.

5.4.3 The Follow-up Service

This section examines the accessibility of pharmacies in comparison to other health care settings. All the participants believe they are approachable and that this provides opportunities for patients to raise their concerns. Accessibility encourages participants to support patients and one of these support services is MUR, which promotes the adherence to medications. This service provides

opportunity to review a patient's adherence to their medication and review other health issues and it enables participants to signpost the patient if they need more support. The participants in this study routinely conduct this service for patients and it is part of the extended role of the pharmacist (Pharmaceutical Services Negotiating Committee, 2013).

Accessibility of the pharmacist to the patient (Sub-category O1)

Participants 3, 7, 8, 9, 10, 11, 17, and 21 made comments in this section. Participants 9 said they understood the importance of being accessible to patients in order to improve relationships with patients who may be less willing to visit the pharmacy. This section discusses the behaviour demonstrated by the participants for making themselves approachable to patients.

Participant 9 said that, generally, patients are aware of his role in health optimisation and this means he can communicate with patients more flexibly than the patient can with physician and other health care professionals who place time constraints on appointments. This unique position encourages patients to visit.

Participant 9: (4 yrs.; qualified; M): ...because you know you see a pharmacist as quite a leading role in the public eye, so it's best to actually, you know, portray that as much as possible. Say like, look you know if you do have any problems you can come back and ...see us because obviously seeing doctors it's a bit of a challenge itself. You know, you don't get appointments till about 3-4 weeks later.

Similarly, participant 11 said that patients are often busy and do not have enough time to receive advice.

Participant 11: (18 yrs.; qualified; M): ...look I know you're quite busy at the moment, you don't want to know any more information but feel

free to come. My telephone number's on the actual label there. If there's any information you'd like to ask me come at a later date.

Participant 11 offers opportunities for patients to contact the pharmacy, opportunities for patients to meet in the pharmacy, and makes time to call patients on the phone for a follow-up. Offering opportunities for patients to contact the pharmacy or telephoning the patient might reminds patients of their appointments. This behaviour resembles that of a social relationship rather than just a professional act. Moreover, Participant 10 strives to support people with depression and this may increase their patients' awareness of health promotion at pharmacies.

Participant 10: (11yrs.; qualified; M): ...I also spoke about, you know, for like a GP you've got make an appointment. Ours is like a walk-in service, so always feel welcome, and I always say that to any of my patients...look, we're obviously here. We're obviously medicine experts so you know, please feel free to just pop in anytime if you don't feel too well.

Participant 10 was confident giving advice about anti-depressants in order to meet the needs of the patients and their expectations. Accessibility encouraged pharmacists to dedicate more time to patients, which possibly changes their attitude towards providing more services to patients. Guerreiro et al. (2010) reports that pharmacies are more accessible than the clinical setting because patients are able to make appointments that fit into their schedule and the availability of the service. The Pharmacy Guild of Australia (2010) explains that the responsibilities of the pharmacist include health promotion, disease prevention, to reassure about the proper use of medications, and general health management. Pharmacies are always the first primary care units, after their GPs, that patient intend to visit.

Advanced services (Sub-category O2)

All participants except participants 2, 4, 7, 9, 12, 17 and 20 talked about their involvement in Medicine Use Review. Participant 4 said Medicine Use Review encourages him to dedicate more time and attention to patients. Even though a review of patient medications recommended for patients with physical diseases, the participants thought this presented a good opportunity to understand patients' satisfaction with anti-depressants.

Participant 4: (MPharm Student; F): ... when I've been in that situation they'll be on other medication and they'll be having an MUR so it will be speaking to them privately for another reason but then they've got the space to speak, really open up to you on how they really feel about the medication and other things.

In accordance, The Pharmaceutical Services Negotiating Committee (2013) explains that other services may be unique to pharmacists, such as the Medicine Use Review (MUR). This helps patients get the best out of their medications. This service is undertaken periodically, or when there is a need to make an intervention to enhance adherence to medications. This service targets patients who use multiple medicines. The participants staged information to encourage patients to understand information and build relationships with these patients. This helps the participants gain the trust of patients and encourages patients to visit for the monitoring of their medications. In accordance, in Wells et al. (2014) community pharmacists felt that MUR provides the opportunity to demonstrate their professional skills and increases patient awareness of the pharmacist's role in health care. In a study by Niquille et al. (2010), the majority of patients were unaware of the medication review service provided by pharmacists, but 41% agreed to a review of their medication led by the pharmacists, and to the exchange of clinical data between community pharmacists and their physicians.

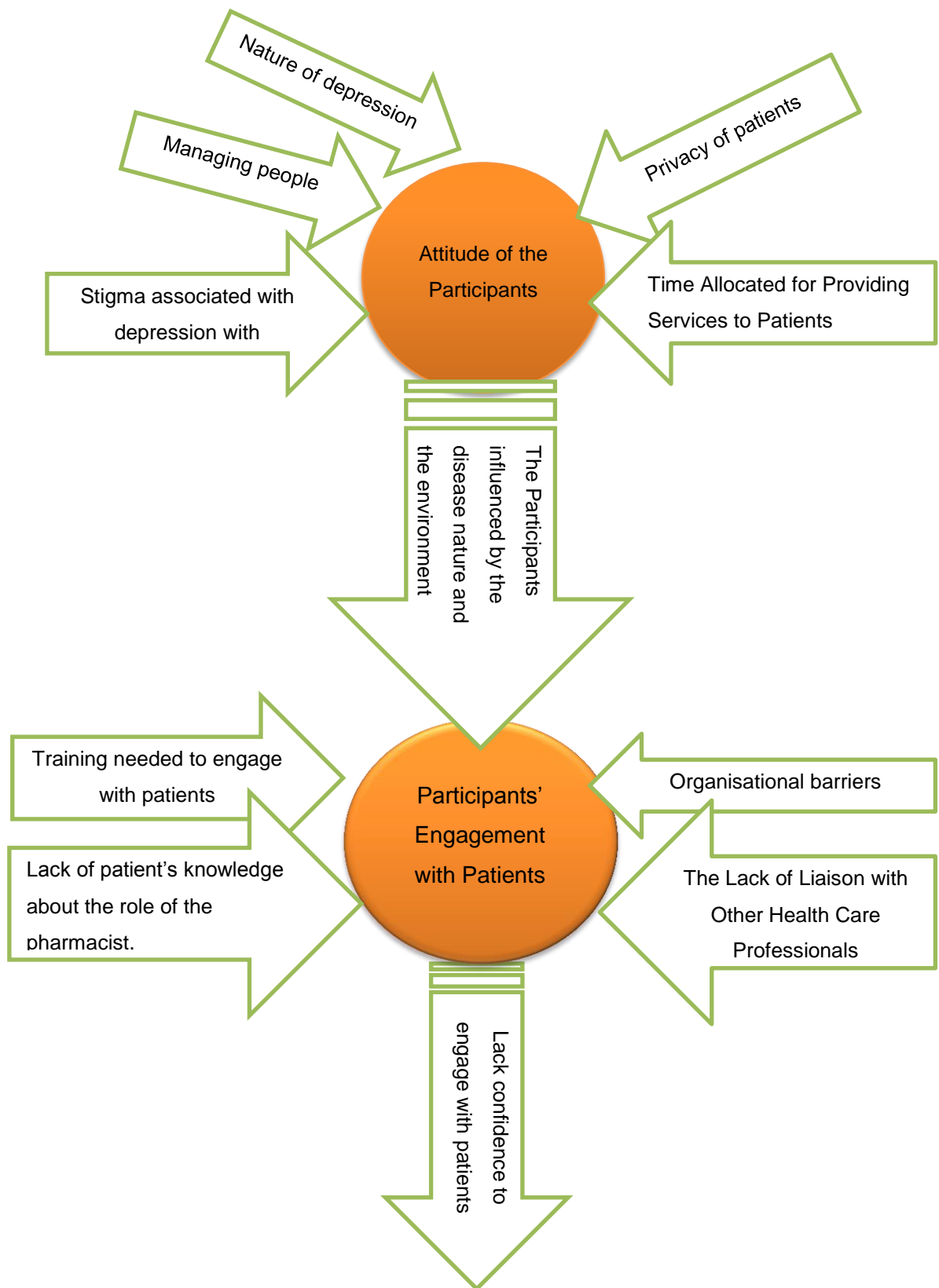
5.5 Summary

In our study, patients with depression indicated that they wanted more attention from the participants. However, in order to achieve this, it is more than likely that the participants will need to enhance their understanding of depression in the future. The symptoms of depression influence how patients engaged with the participants, and the silence of patients often resulted in the participants encountering challenging circumstances when managing people with depression in comparison to managing people with physical diseases. Moreover, a lack of time availability when working in the pharmacy and low incentives for the participants were obstacles which contributed towards circumstances where the participants were less willing to dedicate time to patients. Unfortunately, this dynamic served to enhance feelings of stigmatisation among patients, especially when less attention was paid and less privacy offered. However, these were not only the barriers that worked to lower standards of service for the patients. It became clear that our participants needed more training to engage with patients in order to improve patient perceptions of the extended role of the pharmacist. Difficulties engaging with patients also resulted from a lack of collaboration with other health care professionals, as well as perceptions held about different levels of authority operating within a professional hierarchy. This meant it was less likely for the participants to open up channels of communication between themselves and people with depression. If there is pharmacist-physician collaboration, then this may enhance physician and patient awareness of the extended role of the pharmacist, and then pharmacists can share mutual discussions with patients.

In addition to the lack of collaboration with other health care professionals, our participants lacked an effective computer networking system to link their pharmacies with other health care settings. Introducing, such a system may help to contribute towards overcoming difficulties encountered when engaging with patients. Furthermore, in our study, patients were less likely to tailor services to meet the needs of individual patients, and they showed paternalistic behaviour when dealing with patients generally. Mostly, the participants fostered

one-way communication, which is less likely to work to build up a good relationship with patients. This directive approach also means that pharmacists might not be listening carefully to patient concerns, and this approach makes it more likely for pharmacists to presume patient needs. Staging information is one method that our participants could use to tackle professional challenges, in order to facilitate negotiation between participants and patients.

The next chapter will discuss how the opinions (accounts) and quantitative result integrate to facilitate more in depth understanding of the participants when approaching patients. The data will be synthesised to support the themes, and to show shared characteristics between themes. **Figure 5.5** illustrates the decisions of the pharmacists when offering consultations.



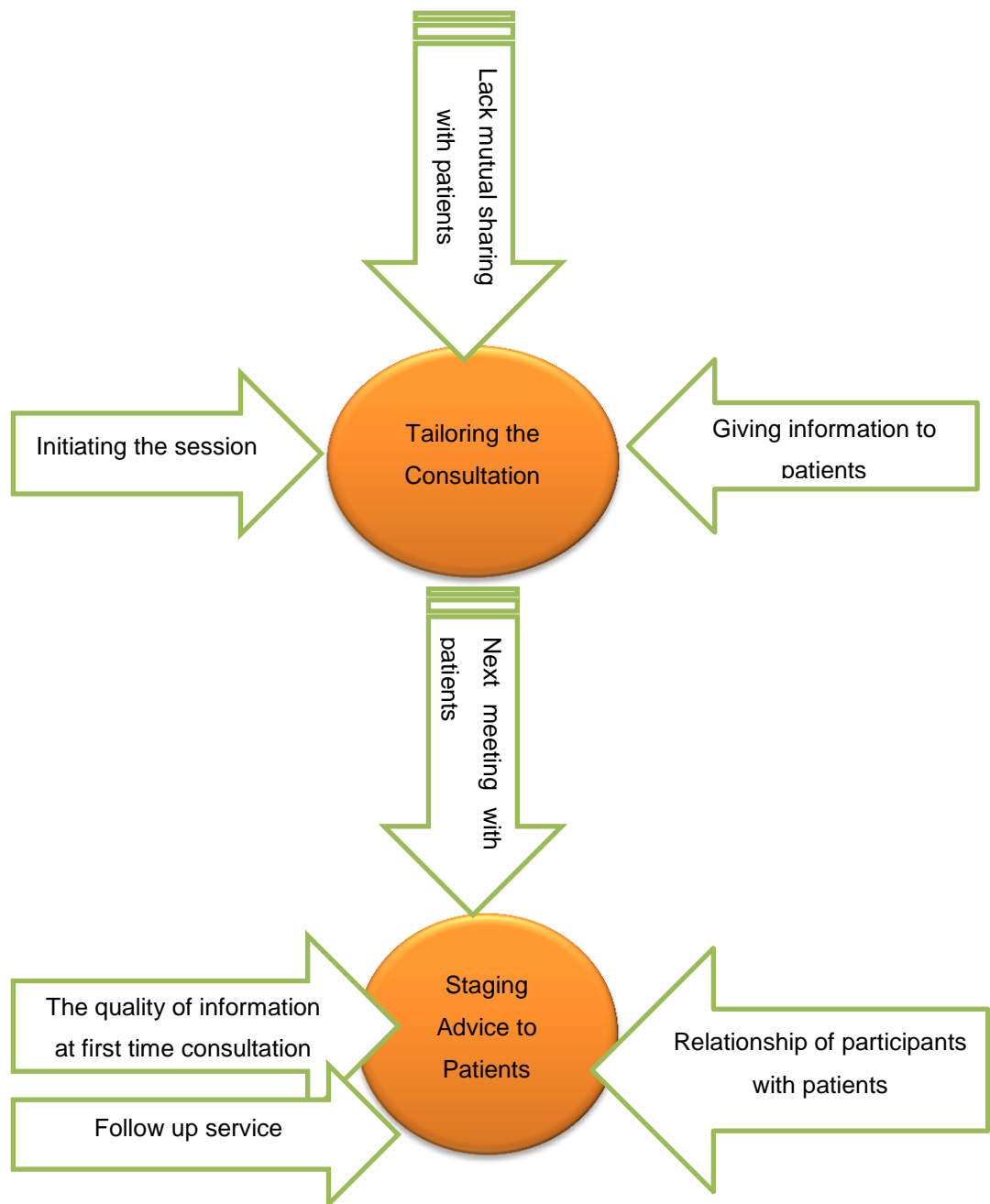


Figure 5.5: The intentions of the participants to give advice about medication

Chapter 6 Discussion

In this study, the number of the participants proved to be limited and this may have made this sample somewhat unrepresentative of Pharmacists at large. This bias was seen as the majority of the pharmacists in the current study were male and the number of female was small. All the results in this study should be read with this caveat.

6.1 The Integration of Qualitative and Quantitative Results

This chapter will describe how data was synthesised in order to develop meaning and to support the qualitative evidence. The quantitative data outlined in Chapter 4 included information about the attitudes, knowledge, observed behaviours, and decisions (performance) of the participants during the simulated consultations. Furthermore, patient satisfaction levels are included the supporting evidence. In this Chapter, the researcher will review the qualitative accounts of participants through reflection (CPD), and will treat this data in a quantitative way.

- The descriptive quantitative data relates to the experiences, feelings and decisions of the participants when they offered services to people with depression. Chapter 4 outlines the knowledge, attitudes, skills and patient satisfaction levels assessed.
- The qualitative findings relate to everyday practice, simulation performance, the participants' reasons for participation, and intended CPD (the motivation to change or develop practice) (see Chapter 5).

The intention of this chapter is to outline and explore associations between the different patterns of behaviour demonstrated by the participants (community pharmacists) when they practice in their pharmacies. This analysis of association will include group and sub-group associations and theme associations. When the research detected links between a set of patterns, the researcher sought explanations for the possible reasons as to why the

participant might be engaging in this behaviour. For example, when a participant said that depression had a negative impact on patients, then possible reasons for this opinion were analysed. One reason why a participant might hold this opinion could be due to holding negative attitudes about people with depression. However, integration of the qualitative and quantitative findings too place in order to support the interpretation.

One recurring theme that became apparent when the findings were analysed was the difficulty the participants had engaging with people with depression and this theme worked as a linking theme to other themes. Although other factor, such as a lack of time and issues surrounding stigma, for example, were main reasons why pharmacists failed to provide a good service to patients was due to difficulties they experienced when engaging with patients. Difficulty encouraging patients to share information led to participants focusing information provision on the action and side effects of anti-depressants. Furthermore, the relationship between the participants and patients was paternalistic, and the reasons for this explored.

The quantitative results and qualitative findings are located in the relevant literature.

6.2 The Attitudes of the Participants in Practice

Overview of the theme

Life events and significant lifestyle changes can often be predicting factors for depression. Bereavement, divorce, illness, problems associated with employment, and financial issues or stress following trauma can all trigger an episode of depression. Furthermore, adverse psychosocial factors resulting from deficient parent nurture, emotional and physical abuse, neglect, and parental separation may also induce adult depression (Moy, 2009). Attitudes towards coping with and managing depression are also relevant to this theme (Brosan et al., 2010). The participants also mentioned issues about actual and perceived stigma, and this influenced communication between the participant and the patient (British Psychological Society, 2014). Also, attitudes towards and the ability to provide a private consultation influenced this theme. NICE recommends that a patient-pharmacist consultation environment should be conducive to discussion to make the patient feel respected, particularly when discussing sensitive and personal issues (NICE, 2012 C).

6.2.1 The Nature of Depression

A wide range of psychological and social factors have a significant impact on the causes of depression and responses to treatment (NICE, 2009 A). This category examines actual and perceived causes of depression including patient coping mechanisms and the perceptions of the participants. The quantitative results found that 68% of the participants thought that negative life events was among the causes of depression (Section 4.2.4, Domain 4). These findings might indicate that the participants have substantial experience dealing with patients with social or life problems, and this is why they identified these causes as being primary. The same opinions also emerged in the qualitative research, during discussions with participants about the nature of depression, when it became clear that they thought lifestyle was a main risk factor in depression. One-third of the participants thought that social environments enhance the risk of depression. Participant 15 shared common opinions about the cause of

depression. He felt that stressful events such as the loss of a job, the death of a friend or relative, and an erratic lifestyle causes depression. The participant highlighted that poor social relationships are a risk factor for depression. A third of participants cited these reasons as the main causes of depression.

Participant 15: (3 yrs.; qualified; M): The lifestyle yes. Just simple things like do you live at home and then that triggers an alarm bell. This person lives at home, they don't have much contact with other people ... these are all things that are contributing towards the depression.

Although the participants could not pinpoint exact causes, they felt that social environment influences the incidence of depression. Indeed, social factors, such as a change in personal circumstances and life events are among the highest risk factors for depression: long-term unemployment, long-term isolation, and stress can all cause symptoms of depression (Beyond Blue, 2015). Sometimes there may be an obvious reason for becoming depressed, and sometimes not. The reasons may sometimes seem obvious, for example, a relationship breakdown or bereavement (Royal College of Psychiatrists, 2012). The quantitative results showed that 27% of participants thought anti-depressants are addictive, while 12% remained undecided. It is probable that they believe the medication may harm the people, even though the percentage was low. This may indicate that the participants agree about the impact of social events and it is better if the patients receive psychotherapeutic treatments.

The participants commented that people with depression had less self-esteem and felt more hopelessness. However, the participants were unlikely to be willing to raise patients' concerns, and this might lead to patients being less likely to make decisions about their treatment. Physicians being less likely to involve patients in decision-making. The quantitative results showed that about 68% of the participants reported that patients do not receive all necessary information about depression from their general practitioners or psychiatrists (Section 4.2.3).

Less than half of participants said that depression has a negative impact on a patient's decision to take their medication. They explained that some patients refuse to take their medication because they think they do not have depression. Participants said that patients who do not feel they have depression are the least likely to take their anti-depressants, and the patient's decision not to take anti-depressants is usually revealed when the participant is interacting with the patient. This could imply that sharing quality information with patients may encourage them to make the decision to take their medication.

Some patients may benefit from other treatments apart from drugs. It was found 50% of our participants said that people with depression did not want to talk to them (Section 4.2.3; Domain 3), but the quotation below indicates that patients do make decisions about their medications, and so a wider range of choices for treatment might facilitate better outcomes. However, only a minority of patients held this view.

Participant 8 (7 yrs.; qualified; M): ...but some people might not take it. "No I don't suffer from depression". You get them with a lot of people... "No I don't suffer from depression. If the doctor's given me that, I'm going. I'm never going to take this medicine again."

Van Geffen et al. (2011) find that patients use decision-making when they are engaged in decisions about their treatment. In their study, Van Geffen et al. identify patterns of behaviour that indicate the patient's discontinuation or continuation of medications; they find that patients discontinue anti-depressants when they are less involved in the decision making process. In our study, Participant 8 did not explain the safety and evidence based benefits of anti-depressants to his patients and he used a passive approach with his patients. This behaviour might be linked to evidence outlined in (Section 5.2.3; Sub-category H1) when participants said that the superior authority of physicians often influenced them to not take action when patients raised their concerns. Even so, the participant still has the decision to signpost the patient to the most suitable health care setting so they can get support.

The perceptions of some participants about coping mechanisms did not necessarily reflect behaviour of patients, it showed in participants' attitudes toward people with depression and anti-depressant drugs. These participants, for example Participant 9, felt the intensity of dealing with depressive illness was more significant than with physical disease. The quantitative results showed that 32% percent of participants could not decide whether anti-depressants can change the personality (Section 4.2.4; **Figure 4.7**). These findings may imply that the participants are less optimistic about the outcomes of the use of anti-depressants, and think that people with depression may require further support to recover from depression.

Participant 9 shared the view that patients with severe symptoms of depression are more at risk of committing suicide, but the participants did not think this about patients who have physical diseases. Furthermore, Participant 9 felt that a patient's emotions when dealing with mental illness were more intense than those who are suffering from physical illnesses. This could indicate perceptions about depression as a mental illness in comparison to physical illnesses.

Participant 9: (4 yrs.; qualified; M): Okay but if you compare that to something like anti-depression as such, it's, I believe it's a bit more, and sometimes people find that very grasping. They've got to control their emotions inside which can take a bit longer. You're more at risk of like suicidal thoughts compared to say, someone like, say, you know, hypertension or diabetes.

The quantitative data collected in this study showed that participants had good (knowledge) about managing depression. They were aware of safety issues and the efficacy of anti-depressants (see **Table 4.2**). However, the knowledge of the participants about managing depression was not good enough to sway negative opinions about mental illness, and, therefore, additional training might be needed to change attitudes and to promote a positive attitude among the participants.

O'Reilly et al. find that, in general, pharmacists show more discrimination towards people with depression in comparison with other health care professionals. This might be because pharmacists lack opportunities to arrange follow-up time with patients and they do not have access to the full medical histories of the patients. Greater access to records might lead to less discrimination (O'Reilly et al., 2010 B). When Dipaula et al. 2011 assessed third year pharmacy students (completing elective course work activity) to discover the social distance that is created between people with depression and pharmacists, social distance was recorded as lower than before the participants started their course work, and lower than those recorded among a comparator group who did not complete the course work. The intervention group work included dealing with personal information relating to mental illness, interaction with patients in a hospital setting, and a discussion of their activities with other classmates. The intervention group was smaller than the control group. However, in a study by Liekens et al. (2013), participants received consumer education and one-day training to improve attitudes towards stigma and attitudes towards care.

Bell et al. (2006 A) finds no differences in attitude between third year pharmacy students and pharmacists in Australia with regard to stereotypes held about people with depression. The participants in the study held negative perceptions and preferred to maintain social distance from patients. However, Bell et al. (2006 B) notes that attitudes towards social distance improved after intervention training, including patient led education and tutorial classes, in comparison to the attitudes shown among a comparator group. The greatest improvement seen was that students were less judgemental of people with depression and less inclined to believe that patients were difficult to talk with. These results imply that training can positively change the attitude of students.

Our quantitative results showed that 58% held positive attitudes towards people with depression (see Section, 4.2.4; Domain 4). However, the lowest percentages were recorded when participants scored their ability to provide additional support. Only 46% of participants thought they could provide quality

consultations to patients. The participants felt that physicians do not provide satisfactory information to patients, and the participants themselves were less keen to support physicians or to explore patient needs. This indicates that the participants who took part in our research feel that patients experience difficulty coping with depression and this is comes out in their attitude when dealing with people with depression.

6.2.2 Managing Depression

This section will outline the attitudes of the participants towards the management of depression in comparison with other physical diseases. In the section previous, participants felt that patients experience difficulty coping with depression, and these perceptions sometimes reflect in the participants' attitude towards patients with depression and their management of patients with depression. The next section explores the reasons why the participants do not enjoy providing pharmaceutical care to people with depression. Few participants said that the side effects of anti-depressants are difficult to monitor and that educating patients about their condition is harder when dealing with people who have mental illness in comparison to those who have physical diseases. However, only a minority held this opinion. Participant 20 expressed beliefs about the harmful nature of anti-depressants. He said that anti-depressants can cause harm to patients and he did not feel that prescribing anti-depressants in isolation was a good decision. This might imply a belief that psychotherapy and other therapies are better than anti-depressants, but this might also imply that the participant feels that depression is less serious than physical illness and not require medication.

Participant 20: (3 yrs.; qualified; M): My honest feeling, to be honest with you, is I felt instead of the doctors giving the medication quickly... that's honestly how I feel about every anti-depressants that I give out... the last thing I want to do is get patients stuck on a medication for the rest of their lives or for short-term, so whenever I see any anti-depressants, especially if they've not had it before, my

first thought is could the doctor not have done like CBT, cognitive behavioural therapy or talk to the actual patient first.

The quantitative results showed that 27% felt that anti-depressants are addictive (Section 4.2.1; **Figure 4.1**). It appears, therefore, that our participants were not only less motivated to manage people with depression (provide evidence about safety), but also less eager to provide additional services, which include support to patients and meeting patient related health issues. By contrast, in a study by Cates et al. (2005), pharmacists held positive attitudes towards providing pharmaceutical services to similar patients, and some even said they were more comfortable providing services to mentally ill patients than to physically ill patients. The authors suggest that continuing education programmes might contribute towards enhancing pharmacist motivation for helping patients with mental illness. Black et al. (2009) note a gap between the perceptions of patients (in the outpatients' clinic) about the important services they want community pharmacists to offer, and the actual services offered. However, the pharmacists had received training about monitoring anti-depressants, maximising their effects and educating patients about safety of medications. The authors do not give reasons why their sample of pharmacists decided not to offer more help to people with depression, but they suggest a possible mismatch between the pharmacists and the patients about expectations. This links back to our findings (Section 4.4.1; Skills Section1) that show our participants are less willing to negotiate an agenda with patients and identify their beliefs. Possibly, the participants in our study need more training, which may change their attitude towards engaging with patients.

Crockett et al. (2009) note how the attitudes of community pharmacists changed after they received training involving physicians and psychologists. Their study reports that community pharmacists who were able to engage with patients about their anti-depressants were more motivated to refer customers who exhibited symptoms of depression to physicians and medical charities. However, the author use pharmacist self-report as indicator for improvement of their attitude , while in our study patients were involved . Similarly, Scheerder et

al. (2008) note that a lack of education about mental illness acts as a barrier to community pharmacists when they try to provide additional information to patients, and when they try to extend their role. The authors suggest that if pharmacists wish to expand their role in this field, then they need up-to-date training on a regular basis. However, the sample size in this study was small and, therefore, the results might not be reliable.

In Gardner et al (2001), when patients visited to collect their medications they remained unaware that pharmacists could provide advice about monitoring medications. However, the study did not make comparisons with other conditions. This implies that pharmacists might be less willing to take active action with people with depression. The majority of pharmacists recalled having had formal training about anti-depressants in the previous five to ten years, and this result might indicate the necessity for introducing regular training in order to enhance their ability to consult with people with depression. Similarly, in a study by Sleath (2002) only 10% of their sample of patients had received education about anti-depressants. The main reason suggested for this was that both patients and pharmacists are uncomfortable talking about anti-depressants, and that patients might have higher levels of adherence to their medications if they received better quality information from their physicians. Some patients had taken anti-depressants previously and it might be that the pharmacist assumed that patients already had information about their anti-depressants. Chong et al (2013 C) argue that shared decision-making influences patient behaviour and attitudes. They state that the social stigma surrounding depression often leads to negative perceptions and prevents patients being motivated to share decision-making. The authors also find that the stigma surrounding depression can sometimes lead a patient to conclude they are not suffering from depression, and not to seek medical help or discuss any concerns they have about anti-depressants.

6.2.3 The Stigma Associated with Depression

The participants perceived that people with depression feel stigma when visiting their pharmacy (Section 5.1.3; Sub-category, C1). Worries relating to these perceptions meant that the participants were less willing to take a proactive role in offering a consultation to patients. Half of the participants highlighted the issue of patient self-stigmatisation and said that this is sometimes aggravated when patients visit the pharmacy to collect medicines. These participants explained that 'non-verbal cues' can act as indicators that patients are not willing to talk about their medications.

Participant 2: (12 yrs.; qualified; M): They've just been through it all with the doctor, they've just, you know, been faced with something they don't want to be faced with probably... I think it's probably the experiences I've had with patients that don't wanna talk to me and patients who do wanna talk to me... its maybe how they come in and how they appear to begin with.

The participants were more likely to take a negative approach and not offer a consultation, and, therefore, patients with more severe symptoms do not receive the correct help from the participants when needed. This behaviour indicates that participants take non-verbal cues from patients in order to make the decision to engage or not to engage with patients, rather than asking patients if they need more information. However, not knowing about the availability of a consultation room at the pharmacy prompted this reaction. Furthermore, the participants admitted they made decisions based on 'non-verbal cues'. They said they often take the decision not to discuss medications or offer a consultation when they think the patient has a 'weird frown' or was 'less active' (among other cues). This indicates that participants might not be interested managing people with depression in comparison to those with physical illnesses and this makes them less inclined to communicate with people with depression. In consistence with this, a study carried out by The Royal Australian and New Zealand College of Psychiatrists (2009) finds that some patients with depression believe they are a burden to other people and do not

deserve to live; this study also finds that people with depression can be reluctant to raise their concerns.

A cross sectional study by Bell, et al. (2008) assesses the attitudes of pharmacy students towards people with depression. Students across six countries hold negative stereotypes about people with depression. Although the authors initially suggest that people working in developing countries display more prejudice against people with depression, the results showed that even students in developed countries stigmatise people with depression. The author indicates a need to increase student and patient interaction during initial training in order to promote better attitudes towards patients with depression. In contrast, a cross sectional study in Canada by Black et al. (2009) which assesses patient satisfaction and perceptions at an outpatient clinic finds that most patients do not experience significant levels of stigma or discrimination at their community pharmacies, but these results might reflect that the outpatients have already been receiving treatment that gives them relief from their symptoms. A study by Lam et al (2015) finds that practitioners who have a diploma in mental illness hold more positive attitudes about people with depression than professionals who have not had training. The authors used self-assessment to record results in this study, and, therefore, if the professionals had undertaken observation in practice then the results might have been different. These results indicate that our participants might benefit from practical on-the-job training about mental illness.

In a study using descriptive statistics to compare the attitudes of medical (pharmacy and nursing) and non-medical students (studying mathematics and applied social sciences) towards mental illness and patients who had depression, nearly a quarter of the participants held negative attitudes about mental illness. The main stereotypes held by the participants were that patients with depression are dangerous and aggressive. However, the medical students surveyed showed more positive attitudes toward mental illness than those not studying medicine. The authors suggest that medical students are more knowledgeable about mental illness and this leads them to greater self-

awareness when communicating with people with mental illness (El Magd and Al Zamil, 2013). Although our participants possessed good knowledge about the management of depression, they showed a negative attitude towards managing people with depression. This may imply that acquiring further knowledge about depression may encourage a more positive attitude towards patients with depression. When Patten et al. (2012 A) studied two randomised groups of students, one group had early intervention training and another group had late intervention mental health education. The group who received late intervention training did not participate in contact-based education, whilst the early group had contact with patients who had experience of depression or who were in a period of recovery. The students who received contact-based education recorded significantly fewer tendencies towards the stigmatisation of people with depression in comparison with the other study group. However, in this study, 73 percent of the participants were female, and so these results might have been different if the sample demographic had included more men. O'Reilly et al. (2010 A) use a self-reporting method to collect data to explore the effects of consumer and caregiver-led education for pharmacy students on the exploration of goals and challenges. They studied a focus group for between six and eight weeks, and, over time, patients showed a more positive attitude to the pharmacy students. The contact with mental health consumers in a safe educational setting provided the pharmacy students with greater insight into the challenges surrounding mental illness, and contributed to a self-reported decrease in their tendency towards stigmatising mental health problems. The students also self-reported behaviour changes in their professional pharmacy practice.

Using semi-structured interviews, Knox et al. (2013) found that patients sometimes experience stigmatisation from staff and other patients in the pharmacy. The authors suggest that the attitude of health care providers might improve if they enhanced their knowledge about mental illness. The authors did not make a distinction between the pharmacist and other staff, identifying instead the 'health care giver' in the pharmacy. Our participants felt that the skill mix (Section 5.1.3; Sub-category C2) in the pharmacy might possibly increase

the incidence of patient stigmatisation. A third of the participants felt that support or technical personnel might demonstrate negative attitudes towards people with depression, or might not be able to communicate effectively with these patients. Other participants noted passive behaviour among support staff, which might possibly come across as an unwillingness to help patients. This might lead some patients to feel they are not welcome in the pharmacy. Most shared views similar to Participant 17, who said that support workers are often busy in the pharmacy and so do not have time to give a great deal of attention to patients. This participant said that patients seem to feel more comfortable when no other members of staff are around to 'overhear' conversations. However, this participant did not perceive stigma to be an issue, or that the presence of other people generally, including other professionals, might make a patient feel uncomfortable.

Participant 17: (5 months; qualified; M): Other staff tend to be doing their own jobs in the back, and it depends on the size of the dispensary. Generally speaking, staff see this all the time anyway, and they get to know their patients well, and they know exactly what medication they're on, cus they label and dispense them all the time...if the patient was uncomfortable with having that sort of discussion with me in front of my staff.

Participant 19 supported the idea that feelings of stigma may result from the presence of support staff in the pharmacy. However, this participant did not feel that complete privacy for patients was essential, and she assumed that patients were comfortable as long as other support staff were busy.

Participant 19: (28yrs.; qualified; F): And there's other members of staff in the shop area doing the work that they, that they, do so the reason why I stood there is because there was nobody else there...you get like a little window on the side of the bench where the pharmacist can speak to patients like face to face, not going into the consultation room.

Hattingh et al. (2015) use semi-structured interviews to explore Australian consumers who suffer from chronic disease. Consumers had limited recognition of the technical role of the dispensary assistant, and some consumers felt that pharmacy support employees were unqualified. These consumers probably came in to see pharmacists because of chronic diseases. However, it was unclear in the study why these consumers felt unsatisfied with the support staff. In another study, patients with mental illness were concerned that pharmacists and support staff would over hear their medical issues, or become involved in the conversation during the pharmacy dispensing process (where one support staff member takes the prescription and another staff member hands the medication to the consumer). However, this convenience sample may not be representative of other patients' opinions (McMillan, et al., 2014). In our study, support staff did not take part in the research, and so it may be worth exploring their opinions in the future.

A varied skills mix in the pharmacy is more likely to enhance stigma when staff have not received training to interact with mental illness. However, the stigma may increase when the professional (pharmacists) pay less attention to patients. This means that patient may feel less prioritised and time pressure is one of the issues to affect this feeling. The next section discusses these issues.

6.2.4 Time for Providing Services in the Pharmacy

This section explores the participants' attitudes towards time. In the main, the participants noted that GPs experience time pressures, so have less time to dedicate to patients.

The majority of participants felt that pressures on GP time resulted in GPs being less involved with patients and their treatments. For example, participant 13 said that many patients visiting his pharmacy did not possess enough information about their diagnosis and did not know how to take their medications. However, the participant also said he did not have enough time to dedicate to patients in order to fill the gap in patient care.

Participant 13: (5 months; qualified; M): Sometimes doctors just give it out ... No they're under time constraints as well... In real life, they'll just give that out without exploring it in great detail. Patients do not know about their treatment and their diagnosis, not much intention, take your medicine and go away.

In agreement, Anderson and Roy (2013) find that patients are dissatisfied with their communication with their GPs. Patients said that their GPs did not pay much attention to them and did not give them the opportunity to talk. However, the participants in this study were young and were not representative of other ages. Furthermore, Lussier and Richard (2009) claim that patients prefer it when GPs listen to their concerns and patients give out cues to indicate they need more attention from health care professionals. Indeed, Lussier and Richard (2009) find that patients sometimes test providers to see if they respond to their cues, and this strategy helps patients decide if they can discuss issues with providers. Likewise, Malpass et al. (2011) find that patients who take anti-depressants do not often voice their opinions or agendas; they are not ready to tell their general practitioners about suicidal thoughts in order to protect general practitioners from panicking. Possibly, therefore, offering more time might help to promote the patients' agenda. One limitation of this study, however, is that patients had to record their GP consultations. Nonetheless, these findings agree with our study where the participants reported that a lack of time is one of the obstacles encountered by physicians. Over 68% of our participants disagreed that patients with depression receive all necessary information about their disease (Section 4.2.3; **Figure 4.5**). Moreover, less than half of the participants agreed that patients receive all necessary information about their anti-depressants while a third of the participants' were undecided about this. In agreement, Tarn et al. (2009) find that GPs acknowledge the importance of explaining the side effects of drugs to patients and try to build up relationships with patients. However, they report that time pressure is a barrier to providing enough advice, and that GPs often signpost patients to receive information from pharmacists.

Although the participants in our study reported that physicians have limited time, the participants also said that workloads in the pharmacies acted as a barrier to them being able to provide enough time for patients. Even though the participants felt it was important to find the time to dedicate to patients, planning for time took place in advance and was typically short in span. The quantitative results found that only 57% of patients agreed that participants were available to answer their questions (Section, 4.7; **Table 4.8**).

The participants reported that it was difficult to have coherent consultations with patients. This was due the many different services offered at the pharmacy, and the need to multi-task. The participants explained that support staff often interrupted consultations to ask pharmacists to check prescriptions. This implies that the environment in the pharmacy is very different to the setting of the physician's office and that, sometimes, it is difficult to offer one-to-one quality consultations with patients without experiencing interruptions. They said that they could not provide patients with their full attention during consultations, and that they are not always able to pick-up on patient cues.

However, the participants that did not offer private consultations might have encouraged negative patient perceptions about time pressures, for example:

Participant 8: (7 yrs.; qualified; M): ...so the flow of the conversation wouldn't be as good as a physician... but there's also the, the dispensing role which is again...but there is still that dispensing...and I'm not in a position to discuss clinical things or important...and got interrupted ...and there's always that risk of right I'm gonna get pulled into the dispensary again.

Mehralian et al. (2014) argues that one barrier to developing the pharmacist-patient relationship is the commercial nature of pharmacies. The authors argue that pharmacy owners sometimes encourage their staff to focus on making profits rather than providing services. This implies that the commercial and business obligations motivate pharmacist when providing patient care.

However, this study took place in Asia. Linking in with this, Harding and Wilcock (2010) suggest that time constraints and work pressures influence the quality of services in UK pharmacies. Their study assesses the opinions of pharmacists relating to the integration of MUR in their practice. They find that a lack of time was one of the main reasons for introducing MUR in order to encourage pharmacists to focus on medication related issues, but engaging in MUR means that pharmacists have even less time to address concordance issues.

Puspitasari et al. (2009), the majority of pharmacists reported spending more time on counselling for new than regular prescriptions. About 58% estimated that they generally spent two to five minutes with each consumer collecting new prescriptions, while those collecting regular prescriptions did so for about one to two minutes by 46% of respondents. This may indicate that pressure of time identify the intention of the pharmacists but not the needs of patients. In our study, trying to provide services other than consultations might generate professional conflicts, for example conflicts relating to a pharmacist trying to meet the requirements of the organisation by ordering and checking a prescription for accuracy.

The majority of our participants said they did not have enough time to dedicate to patients, and when they did have time, this time was planned and short. The majority of the participants said this. Participant 14, who shared the majority view, said that he wanted to devote more time to patients and less time to repeat prescription work. However, he allocates time to patients to suit him rather than the patient. He acknowledged that spending more time with patients is more likely to encourage them to take medications properly, but he said that the time he spends with patients does not focus on patient needs due to time schedule constraints.

Participant 14: (3 yrs.; qualified; M): Just another couple of minutes of my time could make a difference, and see if there's any changes been made from the doctor's part...You know, I could chase up on that as well but yes, it did feel like someone was in need for help,

because, one they didn't have enough information, and about the condition as well as the medication. There was a lot to go through and as I, from a person who didn't know anything.

Gardner et al. (2001) evaluated the communications between community pharmacists and anti-depressant users in Canada to find that pharmacists are less keen to spend time educating patients about anti-depressants and are unwilling to consult patients during a first meeting or at the repeat prescription stage. The results indicate that pharmacists might perceive their main role as supplying medications rather than providing pharmaceutical care to patients.

Using semi-structured face-to-face interviews, Hwang and Young (2015) note that time constraints are a barrier to the setting up of adequate consultations for pharmacists in Asia. In their study, pharmacists could only find time to provide information about the administration of medications. In New Zealand, Crump et al. (2011) finds that pharmacists provide core services and extra services. However, Sheridan et al. (2012) finds that although devoting extra time to patients gives the pharmacist extra confidence that they are doing their job properly, time itself does not necessarily mean that quality engagement is taking place between patients and their health care providers. Sheridan et al. (2012) finds that health care providers can engage in consultations with patients without establishing good relationships.

An observational study and interviews with pharmacists and pharmacy staff by Latif et al. (2011) finds that support staff are less likely to meet the needs of patients when the patients really want to speak to pharmacists. In this study, when the pharmacists were busy with other patients performing MURs, support employees undertake personal judgments about whether to interrupt pharmacists or make patients wait. However, the study covered just two pharmacies. Another observational study by Latif et al. (2013) finds that when a pharmacist is conducting an MUR they experience workflow interruption. When Latif et al. assessed the contribution of the MUR in community pharmacies they found that pharmacists conducted their MUR as a quick check activity rather

than using mutual discussion with patients. Latif et al. (2013) finds that pharmacists are very structured in their approach and that pharmacists direct consultations. However, this quick approach does not give patients the opportunity to talk about their agenda. One of the reasons for the use of a quick approach is because time is limited, and pharmacies do not recruit extra staff. This implies that the pharmacists integrate MUR into practice, but very poorly. Furthermore, the dispensing staff became frustrated when prescriptions began pulling up at the front desk, and so they would often interrupt pharmacists in mid-consultation with patients.

Barney and Griffiths (2011) note that time constraints often prevent pharmacists from satisfying the needs of patients, but their data only covers online patients. Grimes and Barnette (2014) explain that ineffective consultation results in the patients' inability to raise their concerns, even when they want to express their feelings about the side effects of anti-depressants. When the patient feels that the pharmacist is dedicating their time and prioritising them, then they are more likely to raise their concerns. However, in a study by Oparah and Kikanme (2006), 56% of consumers rated the availability of their pharmacist as excellent, and they indicated that pharmacists placed a high priority on patient satisfaction, but this study was conducted in Nigeria with the general public (not patients). Therefore, the point of view and context may not be relevant to the situation explored in our research.

The previous section described time pressure as an obstacle to providing good service for patients. One consequence of time pressure is the lack of privacy offered to patients, dealt with in the following section.

6.2.5 Privacy

The participants noted that they experience time constraints, which resulted in them being less likely to be able to give enough attention to patients. One area affected by time constraints was not having enough time to offer privacy to

patients. Patients offer privacy only a few patients. All the participants said that offering patient privacy is important because it enhances relationships with patients. All the participants agreed that offering privacy facilitates their ability to pick-up on patient cues, and encourages patients to feel comfortable enough to raise their concerns. The majority of participants believe that offering privacy provides them with the opportunity to discuss concerns with patients, which, in turn helps to reduce perceptions of stigma that the patient might feel when surrounded by members of staff and other patients in the pharmacy. They felt that offering privacy changes the nature of the environment, which shifts from the busy dispensing environment to a quiet environment. These participants said that privacy makes the patient feel more comfortable.

Participant 11: (18 yrs.; qualified; M): As in you know, what we've discussed, and that, but like I say it's, you know, from a setting into shop floor to ...already gives not just the patient the privacy, yourself the privacy... without feeling that the patients thinking one thing or thinking they're being overheard.

They said that the consultation room is a good place to talk because it is quiet and no other people can overhear, including non-medical staff and customers. The participants implied that talking in the general pharmacy area might make patients feel uncomfortable because of the noisy and busy atmosphere and the presence of other people who might overhear the conversation. Although the participants expressed the desire to offer consultation room to patients and seemed to understand that privacy and confidentiality is preferred by patients, as noted in the previous section, in reality, the participants did not have enough time to devote to patients generally, and this included offering patients private consultations.

However, consultation room is not always offered by the participants, for example, (half) of the participants agreed with Participant 10 who has the choice to hold discussions in consultation room or at the dispensary counter, but he usually determines whether consultations should be offered depending

on the severity of the patient's illness and the type of medications prescribed. This participant indicated that patients who have taken certain medications before already possess knowledge about their medications, and so do not need further information. Furthermore, generally, participants said they are more likely to offer information to patients when they are first prescribed medication, and are less inclined to offer repeat prescription patients advice about medications. Patients are also more likely to read information at first prescription stage (Raynor, et al., 2007)

Participant 10: (11 yrs.; qualified; M): It depends if the first visit or the second visit or depends on the what patients need or want...it depends on like high risk drugs I'd say. So anything that I personally think that someone may have overdosed first, or if someone's having something for the first time, especially if they're elderly and they may forget or, or if I can sort of see that the patient is maybe a bit worried or concerned.

Some participants expressed concerns about premises that do not offer complete privacy. According to NICE (2009 A), offering a consultation room can make the patient feel respected and comfortable. When Krska and Morecroft (2010) conducted a study to determine the views of healthy adults on the importance of activities aimed at improving public health, patients told them that pharmacies are not places where they feel private. Patients in this study felt insecure about sharing personal information with pharmacy staff due to fears about confidentiality; but the majority of respondents were not frequent pharmacy users, with 57% visiting a pharmacy only once or twice a year. However, the experience may change when they have a chronic disease and have consultation in a private room.

When Saramunee et al. (2014) studied the experiences of a focus group including pharmacists, the public and physicians, a significant number of pharmacies provided MUR and pharmacists expected the public to have awareness of the availability of a consultation room, and some patients

admitted they were not aware of the existence of the private room. One drawback of this study was that the sample was exploratory, and, therefore, it is limited to one small geographic area.

In consistence with our findings, in a qualitative study by Gardner et al. (2001) finds that pharmacies lacked privacy and this impaired communication with people with depression. However, the authors also suggest that consultation rooms were under-utilised, and the pharmacists in this study were more likely to offer new patients privacy over those coming in for repeat prescriptions. More recently, O'Reilly et al. (2015) claim that private consultation works to facilitate the screening of patients who might be at risk of suicide, and provides the pharmacist with an opportunity to make a patient feel comfortable and address the barrier of stigma. Indeed, Hattingh et al. (2015) find that patient privacy is one of the main concerns of mental health patients, and that privacy helps to facilitate confidentiality.

In our study, the quantitative results found half of the participants saying that people with depression did not want to talk to them (Section 4.2.3; Domain, 3). It may be that patients were not aware of the consultation room and that participants are not motivated to enhance patients' expectations about the availability of the consultation room. In agreement, a Norwegian study by Mamen et al. (2015) finds that elderly patients have a high requirement for information about medications and one third of patients said that privacy was one of their main concerns, but that the kind of privacy offered in pharmacies differs from that offered in other health care settings. The study also finds a high correlation between the offer of privacy and acceptance of the MUR. Furthermore, the authors found that patients had less interest in using the consultation room because they did not expect the pharmacists to add any other information to that which they received from their physicians. The next section will further explore participants' perceptions of patients' expectations.

6.3 The Participants' Engagement with Patients

The majority of the participants said it was difficult to engage with people with mental illness but that understanding patients and providing additional information was a main concern of most participants. This section can be read in conjunction with (Section 6.2.2) relating to the management of people with depression and can be considered alongside the participants' views about professional self-insight, which were found to be ambiguous and unclear.

6.3.1 The Training Needed to Engage with Patients

Participants said they were less likely to make shared decisions about consultations. They lacked the motivation because they need more education to engage with patients. They perceived that, during the initial stages of treatment, patients are less inclined to involve themselves in mutual discussion. Lifestyle is one of the aspects of an extended therapeutic discussion, which they were not able to advice the patient about. The majority of the participants shared Participant 10 told of his experiences with a patient who had Obsessive Compulsive Disorder and said he felt this patient was not interested in discussing the condition with him. Therefore, Participant 10 formed the opinion that patients are not enthusiastic to share information.

Participant 10: (11 yrs.; qualified; M): But how do you change that? I mean sort of, you know, like, I was saying if you sort of put an animal in a cage it may heighten it you know? If I ask you a lot of personal questions, you're gonna turn round and say well it's the first time we've met. I spoke to one of my patients who has actually got OCD.

It is likely that the above illustrates the opinion of the participant when he casts judgment on people with depression. He may have had experience with some patients who are not very interested in receiving information, but NICE guidelines state that health care professionals should tailor information to

patient needs. This means that the patient's beliefs and preferences are met (NICE, 2009 A).

In agreement with our study, a survey in Canada by Phokeo et al. (2004) finds that community pharmacists prefer to engage with patients who have physical diseases rather than with patients who have mental illness. The pharmacists identified a lack of training at undergraduate level about engaging with people with mental illness, and this might account, in part, for reticence shown when engaging with people with depression. However, the authors of this study do not differentiate between different classes of medication prescribed, for example, antipsychotic and anxiety. Therefore, it is possible that training about engaging with mental illness is required for our participants in order to enhance their confidence when meeting people with depression. A study by O'Reilly et al. (2015) develops a two-hour purpose designed interactive training programme for pharmacists relating to depression screening from case studies. This training programme enhances pharmacists' skills to screen people at risk of depression. The pharmacists demonstrated capabilities to screen patients and provide a risk assessment service for depression. Skills required learned included referral to other care professionals when necessary. This programme was inspired by a previous study of Australian community pharmacists which demonstrated that pharmacists had good understanding about the treatments for mental illness and were able to identify a person at risk of suicide and refer them onto appropriate health services (O'Reilly, 2010 B).

In the main, participants said they were unable to perform the expanded role of the pharmacist and they felt that consulting with patients about non-medication issues was outside of their role. Furthermore, they said they are reluctant to hold two-way consultations with patients. The participants disagreed about the boundaries for eliciting information.

Participant 1: (28 yrs.; qualified; M): You know, there is a fine line with the pharmacist... personal details...how do we get an overview of you? Can we get all that personal information out of you? So

what's happening for example, in your private life? Is it workload stress, or whether it's marital or private relationship stuff that is going on, and that's what's caused the depression, depressive episode.

Liekens et al. (2012) say that pharmacists are confident to provide information about the side effects and medical treatment options for depression, but are less willing to provide social advice to patients who have depression, in comparison to giving out information to those with physical disease. The 57% of pharmacists studied lacked education about mental illness (Liekens et al. 2012 B). This may support a view that our participants need some training to be able to provide non-medical information to patients. Chong et al. (2013 C) suggest that, in order for pharmacists to involve themselves in decision making with patients, they need to learn interpersonal and positive communications skills. Moreover, pharmacists need to undertake continuous professional development in their area of practice. Liekens et al (2014) who studied the impact of one day training for pharmacists in Belgium, supports this view. The pharmacists in the intervention group asked more questions about anti-depressants and lifestyle/psychosocial concerns compared to the control group. Despite the positive impact of training, the pharmacists seemed to avoid gathering and giving information on lifestyle and psychosocial concerns. The control group received no lifestyle information. However, the modest information given by the intervention group encouraged patients to discuss lifestyle and psychosocial concerns, but the authors did not outline why the pharmacists in the intervention group avoided talking about lifestyle. The authors suggest that it might be the lack privacy at the pharmacy counter (Liekens et al., 2014). Our participants said that they have private space, but (see Section 6.2.5) revealed that they offer less privacy in order to avoid expanded discussions with patients, and they felt less able to control the consultation.

Crockett et al. (2009) compares pharmacists given extra training with those who not given extra training. The training concerned the nature and management of depression by a psychiatrist, psychologist and GP, and the intervention group showed improvements in their discussions with patients when they discussed

the safety of anti-depressants. However, the study finds that pharmacists are less likely to engage with patients in order to avoid saying or doing the wrong thing and, thus, risk losing the trust of the patients. This evidence can be linked to our findings showing that participants think that a lack of liaison with other health care professionals hinders communications with patients. The participants were concerned that the physicians may withhold the diagnosis and possibly the side effects of treatment from patients and it would be difficult for the participants to raise this kind of information. The hierarchy within professions can lead to conflicts about the type and extent of information given to patients.

The above explanation illustrates the benefit of skills training to engage with people with depression. However, our participants need more training to engage with people with depression and this may serve to change the orientation (role conflict) of the participants about their responsibilities. The role of the pharmacist–patient relationship is investigated in a cross-sectional study by Worley et al. (2007) and in this study, pharmacists were uncertain if they could start a conversation with patients when the patients did not ask for any help. The authors suggest that pharmacists may need effort to start a conversation if it goes beyond the traditional role of the pharmacist. Furthermore, a qualitative study by Murphy et al. (2014) finds that pharmacy students are unclear about the boundaries between their social and technical roles. The students' experiences were characterised by 'identity pluralism'. Students discussed the enactment of multiple roles in their pharmacies, including the role of 'technician', 'pharmacy student' and 'future pharmacist'. Each of these roles had a self or externally imposed suite of knowledge, attitudes, behaviours, skills, level of responsibility and decision-making authority, but the study only recruited students from one Canadian university.

Our study finds that role conflict contributed to patients being less aware of the participants' role. The quantitative findings show that approximately 46% of patients had confidence in the participants' knowledge about depression and its treatment. This may indicate that patients do not see the participants as

a source of additional information, for example, information about lifestyle. Similarly, in Moja et al. (2013) pharmacists perceived conflict when they tried to advice patients about medications, enforce restrictions on medicine dispensing, and offer consultations. The pharmacists had difficulties in carrying out these various roles, especially at times when patients were able to perceive this and forget the relationship of trust initiated or the provision of counselling. However, the majority of the pharmacists in this study were owners, and so they might have had different agendas to employee community pharmacists. Moreover, the median age studied was 48 years, and due to age and experience, the pharmacists may have held different perceptions to those of newly graduated pharmacists.

When Hercelinskyj et al. (2014) explored how mental health nurses perceived their professional identity the nurses said they sometimes felt their role was rather ambiguous or unclear due to constant changes in government policy or organisational changes. The government wants to play bigger role in training participants and implementing this training in practice. Therefore, it appears that a lack of training of our participants about mental illness can be a barrier to pharmacists engaging with people with depression. This situation exacerbates when role conflict occurs and this serves to prevent the patient being aware of the extended role of the pharmacist.

6.3.2 Lack of Patient Knowledge about the Role of the Pharmacist

The majority of the participants said that many patients did not understand their extended role in practice. They said patients felt that the pharmacist's role was to dispense rather than to give advice about medications. This attitude confirmed that the participants perceived their role as that of a dispenser. Furthermore, one participant said that patients are more trusting of other health care professionals than the pharmacist is because patients perceive that pharmacists cannot make decisions that conflict with those of the GP.

The participants referred to ethical issues in order to articulate perceptions about the responsibilities of the GP.

Participant 10: (11 yrs.; qualified; M): If you ask any person on the street, they'll say yes, the pharmacy offers that, the pharmacy offers that. If you ask a normal person, does your pharmacist talk about mental issues? No. They'd be like, no, I have to go to my psychiatrist...I have to see my GP ...You know, well, why are you asking me so many questions?

During the study, a perception that some patients were unaware of the participants' ability to provide additional roles became apparent. This view did not derive from personal opinion but was drawn from experience. For example, Participant 20 said that people with depression are not keen on his involvement in decisions because they see the role of the physician as a paramount. He said that patients were not generally aware of the function of MUR and, therefore, patients are not receptive to advice from pharmacists. However, the participant did not refer to what patients thought after they had experienced MUR.

Participant 20: (11 yrs.; qualified; M): The patients don't expect the pharmacist to ask those personal kinds of questions. Something called the Medicine Use Review, whenever we ask sometimes, some of the patients to come in for a medicine use review, the first thing they'll answer is, 'Oh it's a doctor's job. I've just had a consultation with the doctor. Why do I need to chat with you?' So that's why sometimes pharmacists tend not to go down that road?

The participants said that patients were less aware of the pharmacist's role and the standard of education possessed by the pharmacist in mental health matters. This possibly indicates that a new system of managing patients may enhance patient expectations of the participants. Youssef et al. (2010) find that patients exhibit positive feelings after they have had an MUR. This study finds that more than half of the patients surveyed learned more about the side effects

of their medications after they had an MUR; patients over 65 years of age reported more benefits from MUR than patients under 65 years of age, especially in relation to the administration and correct timing for taking medications. However, the majority of patients had physical diseases and only a small number had mental illness. This may indicate that patients are aware of the knowledge of the participants, but the participants are less interested in increasing patient expectation or taking an active approach.

Carter et al. (2012) find that patients are more willing to receive a home medicine review when their physicians had recommended one for them. The study also finds that patients are more interested in asking their GPs about concerns they have with medications than in talking to pharmacists. This indicates that patients still hold traditional views about the role of the pharmacist and do not like to speak to pharmacists about issues they perceive are beyond the role of the pharmacist.

Worley et al. (2007) find that pharmacists agree more than patients do about the responsibilities of the pharmacist to meet patients' health care needs. The authors suggest that patients feel some responsibilities lie with GPs rather than pharmacists. This reflects patient perceptions about the pharmacist's role, but this relationship may influence by many factors including the experience of patients, the type of diseases and the location of the pharmacist in the hospital or community. In Bissell et al. (2008), a random controlled trial compares patients who have coronary heart disease with usual care patients. The findings show that patients feel uncomfortable when pharmacists make recommendations after conducting an MUR because of perceptions held that making recommendations are part of the GP's job. This view reflects the perceptions of patients that physicians are the dominant professionals and the professionals who carry out the task of clinical and diagnosis. However, Hughes and McCann (2003) find that this orientation changes when physicians become more involved in community practice and make recommendations to patients to seek pharmacist support. Nonetheless, semi-structured interviews conducted by Morton et al (2015) finds that workloads in the pharmacy sometimes act

as a barrier to pharmacists being able to practice their extended role, but this study is limited in that it includes telephone and face-to-face interviews. A survey conducted in Liverpool suggests that two thirds of the public seek advice from pharmacists about health and medications, but only one-third view pharmacists as a source of advice relating to general health. Furthermore, the patients rated their pharmacy as poor for sharing advice about lifestyle and screening. The patients studied were not generally aware of their pharmacy's capacity for offering to advice about medications, and although the respondents felt that support for people with depression is important, they only felt this was due to pharmacist input to a moderate extent (Krska and Morecroft, 2010).

In the United Arab Emirates, Hamoudi et al. (2011) finds that approximately five to twenty consultations per month relate to drug administration and dose recommendation. They claim this is because patients still hold traditional views about the role of the pharmacist and have not yet accepted the idea that pharmacists can provide cognitive and health management advice, but in United Arab of Emirates (UAE) physicians are available and have time to provide information to patients. It might be that pharmacists in the UAE tend to provide only basic information, and this approach does not promote patient expectations, unlike in UK where pharmacists have the responsibility of providing an additional role, but patients are more amenable to professionals they are more familiar with. Similarly, Sunderland et al. (2006) report that only a small number of people receive information from their pharmacist relating to lifestyle, but, in spite of this, patients are happy to receive preventive advice. The authors suggest this might be because patients can obtain preventive advice from other sources apart from the pharmacy, and are more comfortable receiving this kind of advice from pharmacists also. Consistence with our study only 39% who agreed that pharmacist is willing to talk about patients symptoms of depression and progress with treatment, this may induce less expectation of patient about our participants, while the majority divided into disagreed and undecided (4.8). However, questionnaires and semi-structured interviews conducted in a study by Hoch, et al. (2011) found that pharmacists have a good knowledge of medications and mental illness. Half of the patients surveyed said

they expected courtesy from a pharmacist. In this study, patients came from a social assistance and counselling setting and it is possible that the pharmacists had more contact with patients than our participants did.

In McMillan et al. (2014 B) a focus group comprising Australians with chronic illness took place in order to find out how they viewed the role of their pharmacist. The participants in this study said that the primary role of the pharmacist is to dispense medications and patients were unsure or unaware of other the services the pharmacist provides, such as signposting to other services or a Home Medicine Review. The participants were not sure how the pharmacists could help them. The authors suggest that, maybe, patients do not feel comfortable taking up the pharmacist's time in case this prevents the pharmacist from dispensing medications. In (Section 6.2.4) our participants said they did not have enough time to dedicate to patients. However, in Wheeler et al. (2012) patients said they knew that pharmacists are part of the group of main decision makers involved in their care in a secondary care setting. However, the patients experienced limited contact time and had minimum experience of using a community pharmacist, because their experiences came from the secondary care environment.

The idea of conflict in 'role theory' relates to when a person holds expectations that are incongruent with those of another person, professional or organisation. This situation can cause stress and encourage people to adapt behaviour in order to cope (Biddle, 1986). When Hercelinskyj et al. (2014) conducted semi-structured interviews to assess the perceptions of mental health nurses about their role they found that nurses experienced role conflict and stress about structural issues in the workplace and conflicts between their expectations, responsibilities and the need to perform in the mental health setting. In our study, participants felt role conflict in relation to their roles as dispenser and provider of advice, support services (including consultations), and their commercial role. This indicates that the participants experienced role conflict due to the many responsibilities they are required to provide, therefore, there is

less time to prioritise patients, and, consequently, this influences the expectations of patient about the role of the participants.

In a qualitative study by Niquille et al. (2010), the majority of patients studied were unaware of the existence of the Medication Review as a service provided by pharmacists. However, 41% of patients agreed to undertake a review of their medication led by pharmacists and exchange clinical data between their community pharmacists and their physicians. Nonetheless, most patients were generally unaware of the services provided in the pharmacy. It seems that good number of patients (a) agreed that pharmacists share patient personal information with physicians (b) had accepted a MUR from the pharmacist, but the study did not consider mental illness.

Knox et al. (2014) conducted telephone based interviews were undertaken with patients to assess satisfaction with the services provided in the pharmacy, patients were satisfied with the services provided at their pharmacy, although some services were missed. This indicates that patients might not always be fully aware of the kind of services offered at their pharmacy and the abilities of the pharmacist to provide them. However, when patients described what they liked most about their pharmacy visit, functional qualities (how information is distributed in terms of interaction quality and positive attitudes and behaviours) featured more frequently than technical qualities.

It appears that attitudes about role perception can influence a pharmacist's decision whether or not to practice their extended role. This may not help patients who are not aware of the extended role of pharmacists. However, collaboration between the pharmacist and other health care professionals may raise awareness about pharmacist's role in helping patients, and this might enhance patient expectations.

6.3.3 A Lack of Liaison with Other Health Care Professionals

Two participants said that they did not have much contact with other health care professionals, but felt that collaboration with other physicians would improve therapeutic outcomes, as well as provide opportunities to follow-up patients and enhance their quality of life. Participants said that a lack of liaison with other health care professionals reduces opportunities for managing patient therapies. These participants said they were not fully aware of the information physicians give to patients, and said that communicating information without knowing the patient's needs is not very effective. The participant said that physicians are sometimes reluctant to tell patients about their diagnoses and he voiced concerns about information withheld by physicians.

Participant 2: (12 yrs.; qualified; M): And you don't know exactly, from that what the doctors said, what they've said to the doctor, what other people around them are doing, and those sorts of things.

However, the lack of liaison with other health care providers is only one possible barrier to providing good care. Professional conflict between health care providers can also contribute to less engagement between pharmacists and people with depression. A third of our participants made comments associated with a hierarchy of health care professionals. The participants reported that decisions fell under the influence of higher authorities, for example, GPs and other physicians. Some participants thought they could not take action relating to medications when GPs had already decided upon a course of treatment. The participants felt that, sometimes, patients were not responsive to advice given by them and preferred to consult their GP instead. These participants' experience ranges from 1-18 which may indicate that they hold this concern and the experience does not necessarily tackle the professional conflict with other health care professionals.

Only a minority shared the views of participant 11 who showed disinclination to become involved in raising questions about medication with patients or GPs even when a patient raises concerns because this might bring him into conflict

with the GP. He said that patients perceive the role of the pharmacist as a dispenser who is not active in health care treatment decisions.

Participant 11: (18 yrs.; qualified; M): I cannot change the medication, the decision was made with the physicians, and I suppose it not our responsibility to check if patients are happy with their treatments. We are pharmacists. We have to know our boundary. Encroaching on the role of physicians is hard.

In agreement with our study, Chong et al. (2013C) find that Australian community pharmacists often defer to the decisions of GPs and encounter challenges when they have to raise issues about dosage or conflicting medications. Likewise, Harding and Taylor (2002) find that pharmacists' decisions fall under the influence of other health care professionals, even when the decisions made are less likely to lead to therapeutic outcomes. The general perception is that physicians perform clinical assessments and make therapeutic decisions, and so physicians have more authority to make decisions about patients' health conditions. This recalls the findings of our study when the participants perceived role conflict whenever they felt inclined to give out lifestyle information, and that undertaking their extended role requires significant encouragement. This is possibly link with our own (Section 6.3.2) that people with depression lacked knowledge about the role of pharmacist which make the mutual discussion difficult with patients.

When Kalvemmark et al. (2004) conducted a focus group with nurses they identified the moral distress and painful feelings that occur when constraints on nurses meant that he/she do not do what is perceived as morally correct and necessary. In our study, decisional conflicts between physicians and pharmacists had an effect on the professional performance of pharmacists who felt they had less power to make decisions, and must take orders from physicians. Crump et al. (2011) support this view when they explore the services provided by community pharmacists and barriers to care. They find that other health care providers do not always recognised the role of the

community pharmacist, and that medical practitioners are unaware of the training and knowledge of pharmacists. Furthermore, Crump et al. (2011) find that physicians experience role conflict with community pharmacists who work as health care providers and sellers of medications. However, in this study, some of the participants spoke by telephone and the topic guide was about psychotropic drugs, and so these perceptions may differ when talking about physical diseases. This possibly indicates why only few of our participants who elicit social history of patients (Section 4.4.2; Skills Section 2).

Role conflict between health care professionals can lead to patient needs remaining unmet. A study by Tarn et al. (2009) shows that elderly patients who took part in a focus group were unclear about the role of the pharmacist, and they held different opinions about which care providers are allowed to explain side effects. The study finds that some patients accept information about side effects from pharmacists, others are comfortable receiving information from the physician and pharmacist, and some prefer to talk with their clinician about side effects. However, the patients in this study were elderly, and it is possible that carers play the main role in collecting their medications, and this may have contributed to why they were unable to decide about the role of the pharmacist. The findings of Tarn et al. (2009) are in line with Gidman et al. (2012) who report that supplying medications is the main role of the pharmacist. Gidman et al. (2012) find that although some participants visit community pharmacies often, they have a relatively limited view of the extended role of the pharmacist and their awareness of the extended role of the pharmacist was low. Gidman et al. (2012) find that patients hold very traditional expectations about the role of pharmacists and are more likely to place trust in what is already familiar to them. The study focuses on sociological theory and the patients' familiarity with the services, but it does not address the actual behaviour of the pharmacists. However, in focus groups conducted by White et al. (2012) including patients and carers, the Home Medicine Review (HMR) provides pharmacists with the opportunity to build better pharmacists-physician relationships. Australian recipients of this service said that the HMR enables pharmacists and physicians to collaborate effectively, and this includes sharing information about

appropriate therapeutic plans for patients. These findings link with our own (Section 6.5.2) in that the participants developed paternalistic relationships with patients. This paternalistic approach avoids making any decisions that may not have been in line with those made by the physician.

When Wheeler et al. (2012) conducted semi-structured interviews with health care providers and patients in a specialist mental health facility, the care providers recognised the skills of clinical pharmacists in the management of medications for enhancing care delivery in mental illness. In this study, the participants were aware of the pharmacist's role and collaboration with other health care professionals. However, when Niquille et al. (2010) conducted a qualitative survey they found that one of the biggest problems faced when implementing MUR is maintaining effective collaboration with physicians. The pharmacists in this study said that physicians have little time for this service, and physicians view pharmacists primarily as retailers of drugs; but the data showed that a high number of pharmacists who participated agreed that time pressure is an obstacle, and this creates a barrier between the pharmacist and the physician when collaborating to identify each other's role.

The above shows that a lack of liaison with other health care professionals creates extra challenges for the participants. However, collaboration with other health care professionals means that pharmacists can share expertise in promoting medications. Furthermore, a lack of information sharing about the backgrounds of the patients can also create barriers to good care.

6.3.4 Organisational Barriers

Approximately half of the participants noted a lack of access to the medical backgrounds of patients as a creating a barrier to good service. Participants noted that physicians prescribe anti-depressants for different kinds of diseases and conditions, not just for depression itself, and, therefore, providing the right support is difficult when gaps in information exist. This situation exacerbates when patients do not share information about their illnesses or conditions, and, in this study, this resulted in the participants deciding not to share as much

information as they could. The participants preferred to practise one way communication in order to avoid misunderstandings that might result in losing the patient's trust. Another barrier to providing good service as noted by the participants was the patients' use of multiple pharmacies. Some participants noted that patients sometimes visit different pharmacies, depending on convenience, and did not stick to using just one. They explained that, sometimes, they are not immediately aware if GPs have changed patient medications, and that monitoring a patient over time is sometimes impossible.

Part. 11: (18 yrs.; qualified; M): You don't have access to the records...You don't know whether this patient is, you know, suffering from long-term...and you may not get the important information out of the patient.

Semi-structured interviews carried out in Australia by Chong et al (2013 C) involved medical practitioners (psychiatrists and general practitioners), pharmacists, nurses, occupational therapists, psychologists and social workers. Chong et al. (2013 C) argue that it is essential to have a web-based network set up in primary care because this can improve regular inter-professional teamwork and help to facilitate integrated care plans and discussions among team members, but this study took place only in one part of Australia. McDonald et al. (2010) find that community pharmacists are uncomfortable with using outdated technology in the pharmacy because this means that pharmacists are not able to monitor patient adherence to medications. Moreover, Gordon et al. (2007) claim that using outdated software means that pharmacists are less likely to be approached as a source of independent advice. This means that patients were less satisfied with their system because it did not transfer medical information between different healthcare settings. They cited instances of confusion and inconsistency occurring between primary and secondary care advisers which made patients less decisive about what medications should be taken, and when. There were similar results our study (Section 6.3.4) when patients said they felt less engaged with people with depression because of the lack of background information they had about patients.

Crump et al. (2011) raise concerns about communication between pharmacists and claim that some pharmacists think some mental health patients have transient living situations, and this creates barriers to providing continuity of care. This result is similar to that of our quantitative study Section 4.4.2 (Skills Section 2). Participants were less open to offering consultations without knowing the backgrounds of patients. In line with this, in a mixed method study conducted by Guirguis (2011), pharmacists receive brief training before undergoing integration into the 3PQs approach for two weeks. This is a patient-focused approach designed to assess the patient's knowledge and identify information needs, before providing education; the pharmacists recorded their perceptions of patient interactions, completed a survey addressing self-efficacy and role beliefs toward the 3PQs, and participated in a focus group. However, some pharmacists made incorrect assumptions about the indication for the medication. These decisions have safety and efficacy implications. The majority of the pharmacists in this study were community pharmacists.

It appeared that participants were less likely to engage with people with depression, and many factors influence their practice for example environment factor and self-efficacy factors. However, Chapman (2015) argues that some people resist progressing from the stage of unconscious incompetence to conscious competence, because they refuse to accept and acknowledge the relevance of a particular ability or skill. Chapman (2015) explains that some people maintain certain communication styles out of fear, and they would rather feel secure in what they already do than try out something new. Furthermore, Chapman (2015) suggests that some people are happy try to develop their competence but struggle in doing so. Fisher (2012) argues that people are often reluctant to accept change and deny their abilities to change their behaviour in any way; sometimes this happens whilst ignoring evidence, and when it is contrary to someone's belief system.

6.4 Tailoring the Consultation

The Royal Pharmaceutical Society promotes the concept of 'medicine optimisation', which involves patient-focused care to achieve the best use of anti-depressants. This requires a holistic approach and mutual sharing between the pharmacist and patients (Royal Pharmaceutical Society, 2013 A). When Slade et al. (2009) studied patients in a focus group, patients preferred care providers to ask them about their opinions and goals; all the participants wanted their care provider to develop a comprehensive picture of individual values and preferences.

The responsibility of health care professionals is to acknowledge the individuality of each patient and try to tailor services to meet the needs of individual patients. Values and preferences influence patient expectations and how they use services (NICE, 2012 C). In our research, half of our participants in the qualitative results who made their opinion about initial rapport with patient concerning negotiated agenda, but not other skills of initiating the session.

6.4.1 Initiating the Session

The quantitative results in our research showed that none of the participants introduced themselves to patients when conducting consultations. The participants demonstrated poor quality skills in this area. The only positive behaviour noted was inviting patients to discuss medicines. The participants did not demonstrate other skills, such as outlining the structure of the consultation and finding out the agenda of the patient. The participants did not feel it was important to provide an introduction by name, (Section 4.4.1; Skills Section 1). This kind of behaviour creates a barrier to communication as noted previously, such as patients not visiting the same pharmacy. Therefore, the participants greeted patients in ways they saw fit. Mahesh and Parthasarathi (2004) explained that it is possible to create powerful first impressions when meeting patients and these impressions can affect how patients view their pharmacists. Decisions made about communication can encompass both verbal and

non-verbal communication and unconscious behaviours, and successful introductions can affect the fluency of the consultation.

In a structured observation made by Hussain and Ibrahim (2011), patients were more enthusiastic to greet pharmacists than pharmacists were to greet patients. In this study, 48% of patients greeted their dispenser; but the study involved covert observation, which raises ethical issues of not letting the participants know that they were being observed and it may give unclear response of the pharmacist-patient communication, it is possibly explained data subjected to the observer interpretation, but not to actual communion. Greenwood et al. (2006) evaluated the impact of home visits by pharmacists to patients with heart failure. It also shows that pharmacists do not greet patients before a consultation. However, the authors note that, possibly, some pharmacists greeted the patients before recording started; but the tool used (skill checklist) in the study was designed for the physicians and possibly not suite the pharmacists skills. However, in a cross sectional study by Worley et al. (2007) pharmacists preferred to just say 'hello' rather than provide a personal introduction. This implies that pharmacists do not always observe professional behaviour or demonstrate good soft-skills when they first meet patients. However, the authors note that the pharmacist might not always be the first point of contact in the pharmacy; the patient might well have been greeted by other professional or support staff before meeting the pharmacist. The authors also suggest that if pharmacists were not as focused on dispensing, then they may have more time to greet patients, as well as provide better consultations and information sharing services. This may apply to our study in that our participants often see the patients after the technician who has already greeted patients.

Participants lacked interest in greeting patients, or did not recognise its importance. This may also mean that they were less inclined to explore the agenda of patients. Our participants noted that physicians do not have enough time to advise patients about health services, and this hinders the physician's delivery of an effective service. Participants commented that the number of patients waiting discourages physicians from engaging with patients about their

treatments, and that physicians rely on pharmacists to provide some information to patients. Therefore, half of the participants perceived that initial rapport was more likely to build good relationships with patients, which facilitates advice giving, but they did not intend to build this initial rapport with patients.

The participants thought negotiating agendas provides a good opportunity to enhance patient expectation about the knowledge the participants. This performance encourages patients to clarify their agenda and helps to structure the consultation.

Participant 1: (5 yrs.; qualified; M): I can't see how a GP can come in, in 8 minutes, meet and greet the patient, understand the patient, why they're presenting, take an effective history as to why they're presenting with low mood and the whole social context that it's presenting in... then make a diagnosis on that, then make a prescribing and say I'm going to prescribe you Sertraline.

However, as noted in the quantitative results (Section 4.4.1; Skills Section 1), in practice, the participants did intend to establish the patient's agenda; but their use of closed questions (Section 4.4.5; Skills Section 5), and possibly, therefore, the participants were less able to understand the needs of patients. The short time (5.1.4; Sub-category D2) allocated to consultations shows that the participants usually dictate their own agenda, and do not give time for patients to form their agenda. This (brief) pre-planned participants' agenda sways more towards therapeutic efficacy and the safety of medications. Therefore, in practice, the participants fail to negotiate agendas with patients, and this includes structuring consultations to ensure that the patient gets what they expect from the consultation. In consistence with this, Greenwood et al. (2006) finds that pharmacists fail to negotiate patient agendas to enable consultation structuring and establish patient expectations. This emerges in a study to assess the skills of pharmacist when visiting patients at home.

The authors suggested that the pharmacists talk to patients about their treatment before recording the consultation. Similarly, a study carried out in the UK found that health care providers (counsellors) do not encourage patients to form their agenda while these providers promoted their own agenda (medicine). This reminds us in (Section 5.2.4; organisational barriers) that the participants lack electronic communication systems agenda with other health care professionals, which reduces motivation to negotiate an agenda with patients. It has been found (Pilnick, 2002) that patients were unable to formulate their agenda if they were not encouraged to do so, and were unwilling to participate in the discussion if they did not understand the background about what will be considered. This study used a dynamic qualitative method (conversation analysis) rather than content analysis (Pilnick, 2002).

In agreement, Latif et al. (2011) find that pharmacists are not responsive to patients and tend to use a checklist approach to MURs. In this study, pharmacists offered MUR without planning, which resulted in the pharmacist lacking an agenda and subsequently not being able to encourage the patient to establish an agenda. However, pharmacists were able to summarise information given to patients. The author suggested that pharmacists' heavy commitment to the dispensing process meant there was poor integration of the MUR service into their routine workload; but the study did not show the demographics of the pharmacists, they might not have had training about MUR. A recent study by Chong et al (2014) in Australia, to characterize community pharmacist–patient interactions during consultations involving use of anti-depressants used simulated patients initiate or previously took anti-depressants. The pharmacists did not encourage patient to negotiate their agenda. Patients were passive whilst pharmacists were dominant during consultations. The pharmacists demonstrated low levels of questioning open questions. In this study, 25 % percent of pharmacies did not offer private consultations, and this might have contributed to the tendency of pharmacists not to use open questions during interviews.

Falvo (2010) find that pharmacists are able to encourage patients to raise an agenda by asking open-ended questions, which enables them to encourage patients to respond more easily. This approach also enables pharmacists to gather information about the patients' understanding of their medications and illnesses. Open questions assess verbal and non-verbal behaviour. It appeared that our participants did not encourage patients to establish their own agenda, but the participants' agenda was to give basic information about anti-depressants without giving more attention to patient concerns.

6.4.2 Giving Information to Patients

Participants said they are competent when giving out information about anti-depressants. They said their priority is to educate patients about the actions and effectiveness of anti-depressants. The participant said they are keen to enhance the expectations of patients and ensure they understand their medications.

Participant 8: (7 yrs.; qualified; M):... and it was a discussion on what the tablets are for, and just to, kind of, give the patient as much information as possible, predominantly on the tablets and how they work...so this patient needs to leave here with the information with regards to his tablets...that was my initial thinking, so that was my aim, to have this patient leave with all the possible knowledge they need.

They said sharing information provided a good opportunity to communicate with patients, especially patients who may be taking medications for months, and when the risk of non-adherence is high. Participants said they are keen to increase awareness about the side effects of anti-depressants, which can lead to eventual non-adherence. They said that giving out information about the side effects is good practice behaviour, but said that if this information tailors to individual lifestyle then this might enhance the positive action of anti-depressants.

The study showed that participants were more likely to provide advice about anti-depressants and less about social treatment (see Section 4.4.3, **Figure 4.12**). Consistent with our evidence, a study used unannounced simulated patients to assess the pharmacist-patient communication in a 6-month period. The study found most pharmacists (90%) explained that it would take 4–6 weeks for antidepressant medications to show an optimum effect, while only 20% of discussions involved lifestyle/psychosocial activities. The authors used three simulated patient visits concerning antidepressant adherence-related scenarios at different phases of treatment, two scenarios involved patients on established therapy (Chong et al., 2013 A), which is unlike to our simulation of a new patients.

In Tarn et al. (2009) patients registered dissatisfaction with their care providers for not explaining side effects for medications. The study noted disagreements between health care providers about information provided to patients. The pharmacists placed emphasis on explaining the side effects rather than the benefits of medications because they wanted to promote safe medicines use. The prescribers' role covered talking about the rational and therapeutic effectiveness of medications and the pharmacists' role was to provide cautionary information; but the study did not define the health condition. This reminds us (Section 6.3.4, organisational barriers) that the participants felt it difficult to provide information to patients because they lack a proper communication system with other health care professionals. This would allow them to be aware of patients' health background, especially for older patients. Dyck et al. (2005) argue that this might explain why pharmacists are not keen to name all the side effects of drugs, but patients who did not receive information about the side effects of drugs registered dissatisfaction with the pharmacist's care and they were more likely to have a negative experience.

Grimes and Barnette (2014) argue that pharmacists made judgments based on their perception that patients were more willing to receive advice about anti-depressants than about lifestyle. Patients possibly have different views, but a pharmacist should be non-judgmental and put the consumer at the centre of the

consultation, which aims at empowering patients and shared decision-making; this made them feel appreciated and redressed the balance of responsibility within the consultation.

However, in our qualitative work few participants felt that they check patient understanding, but this did not happen in the quantitative results (Section 4.4.3, **Figure 4.12**). Hassell et al. (1998) present similar findings in an ethnographic study combining patient interviews with non-participant observation of interactions between consumers and pharmacy staff. Pharmacists used unsolicited instructions (closed questions) to talk about medicines, and did not use extended explanations. The pharmacists' advice comprised brief and directive messages about dosage and administration. This possibly indicates that the pharmacists were unwilling to meet the patients' needs. Similarly, an observational study by Latif et al. (2011) found that pharmacists did not check patient understanding at the repeat prescription stage and assumed that patients already had knowledge of the side effects of medications. The busy environment in the pharmacy made the pharmacists less willing to provide extra support to patients, and pharmacists perceived that patients received education from their physicians. Time pressures (Section 5.1.4; Sub-category D2) may also have hindered the participants in our study when checking patient understanding.

Similarly, Collum et al. (2013 A), used a cross-sectional design (telephone interview) to collect information about the pharmacists' use of health literacy based communication techniques for example, teach back, patients' expectations for their use, and overall satisfaction with communication. They found 20% of patients said that the pharmacist asked questions to check that patients knew how to take their medication. However, this percentage recorded first time prescriptions and checks made at the repeat prescription stage recorded as low. This study found that patients did not expect the pharmacists to engage in consulting behaviour. This reminds us (Section 6.3.2) the participants felt that patients were less aware of their role; and both pharmacist and patient lacked motivation to engage with each other. The study finds that

58% of interactions between pharmacist and patients did not involve checking patient understanding of instructions. There was a tendency to give information without repeating back and the study took place in an Arabic country. The authors did not state if patients had taken their medications previously, and the pharmacists may have thought their patients were already aware of their medications (Alomar, et al., 2011).

In Puspitasari et al. (2009) the majority of pharmacists felt they were not required to provide information to patients who visited at the repeat prescription stage, but they felt that giving out information was important at the first prescription stage. The pharmacists assumed that patients taking regular medications were aware of the side effects of their medicines and so there was no need for further consultation. This may link to our findings (Section 5.2.3) showing that a lack of liaison with other health carer professionals is one the main factors leading to participants' assumptions about patients' needs. Likewise, Schommer and Wiederholt (1994) find that pharmacists make decisions about whether or not to give out information depending on whether the patient visited for a first prescription or for a repeat prescription, and those calling in at the first prescription stage were less familiar with medications prescribed. However, Gordon, et al. (2007) find that patients who take regular medications do not always understand their medications. Out of 98 patients with chronic conditions, 28 had a poor understanding of their regular medicines due to the lack of advice given out about the use of medicines. They reported that physicians appeared reluctant to communicate information or to use understandable terms. They also said that advice and information from other sources was not a substitute for information from health professionals as it was not specific to their needs.

Consistent with our study, Farrel et al. (2009) find that 72% of interactions between physicians and patients lack the use of teach back, and during the majority of patient-physician interactions physicians use closed questions. To check agreement or understanding 21% used the word 'OK'. This is similar to our quantitative study (Section 4.2.3, **Figure 4.5**), that 18% of the participants

agreed that people with depression did not receive necessary information about depression from their general practitioners and psychiatrist.

Negarandeh et al. (2013) conducted a randomized controlled trial to study the use of teach back techniques (using pictorial images and verbal instructions) and an assessment of knowledge and adherence (in relation to diabetes and medication) pre and post intervention. The patients in the intervention group showed more improvement in their knowledge and in adherence to their treatment than in the control group. However, the study used self-reporting rather than objective measurement, and so this might have affected the results. This may relate to our findings (Section 5.2.1) that the participants need more training to engage with people with depression.

Although the participants in our study were aware of the importance of teach back to ensure patient understanding, they were less likely use this technique with patients. They may feel less comfortable to use it with people with depression. It might be the participants found new patients less interested in listening to them and therefore reduced the amount of information for (and/or perceived stress on) the patients. The participants were motivated to break down information to enable patients to understand advice and encourage adherence to their anti-depressants.

6.5 The Staging of Advice to Patients

The staging of advice refers to the measures taken by pharmacists to give out advice to patients. It includes taking measures to reduce the stress for patients and making them feel comfortable enough to be able to absorb information. First time consultations provide the opportunity to give out information about the side effects of drugs, and pharmacists must think about how to frame talking about these side effects. Follow-up visits provide pharmacists with the opportunity to gather more information with the aim of building a relationship of trust.

6.5.1 The Quality of Information at First Time Consultation

Guidelines for pharmacists to break bad news are less common than those issued for physicians and nurse, and pharmacists may find this challenging. Participants said that soft skills frame side effects and offering medication advice. They said that patients become concerned if they perceive that side effects will influence their lifestyle. They said that achieving a balance between negative and positive information was more likely to result in a reduction of patient stress and help patients to remember their instructions. Participants explained how it was important to frame the side effects to reduce the fears of patients. They said that competent providers are able to build therapeutic relationships with patients. They said that giving out the correct information to reassure patients about experiencing side effects not only makes the patients feel at ease, but also helps to develop trust in the provider.

Participant 2: (12 yrs.; qualified; M): I'm gonna be sleeping a lot more now. If you say to somebody well actually it's gonna make you really really drowsy, they might say I don't want that...I wanna be alert.... You might not feel like you wanna eat and actually that sounds like a negative thing. And so saying to somebody you're gonna get insomnia. I explain things in a way that I think most people will understand.

Consistent with our study, Garfield et al. (2004) show that at a first meeting the pharmacist usually gives out advice about potential side effects and the expected benefits of taking anti-depressants, this encourages patients to make decisions about their treatment and addresses concerns in the context of patients' lifestyles. According to Rabow and McPhee (1999), physicians were less likely to focus on emotional distress, but rather focus on relieving patients' bodily pain. Physicians possibly view suffering as beyond their professional responsibilities. However, by concentrating on physical pain, clinicians may be ignoring important elements of meaning to the patient as a person, thereby intensifying suffering (Rabow and McPhee, 1999).

Gallagher et al. (2010) conducted semi-structured interviews in which mental health service users recounted key moments when good or bad news gets to them and described the impact of that news on their psychological well-being. They found that psychiatrists are happier to use terms such as anxiety and depression in discussion, but are less happy to use the term schizophrenia in conversation. Furthermore, Shaw et al. (2013) find that, during hospital encounters, physicians find it difficult to 'break the news' to patients and some physicians try to distance themselves from news which may trigger emotional responses with patients. Physicians avoid talking about feelings by placing the conversational focus on bio-medical information (Shaw et al., 2013). This may remind us (Section 5.3.3) that the participants focused on anti-depressants and were less willing to give advice about social information. This avoided any uncontrolled patient emotion, which was beyond to the (perceived) skills of the participants.

Bays et al. (2014) use patient simulation to assess the skills and emotions of subspecialty and practitioner nurses; feedback gained from patients highlighted improvements in communicating bad news and expressing empathy. However, the sample size was small. There is a lack of studies about breaking bad news with regard to pharmacists' practice. It may be possible to design a format for pharmacists to break bad news to people with mental illness.

Pharmacists lack guidance about how to discuss the negative actions of anti-depressants. NICE (2012 C) recommends that when explaining risk and benefit factors to patients, absolute risk is better than relative risk: for example, saying that the risk of side effects is 1 in 1000, rather than double the (background) risk. The guidelines also recommend using frequency rather than percentages, for example 10 in 100 rather than (10%). Moreover, the guidelines state that patients can interpret the meaning of descriptive terms in different ways, and so expressing risk numerically makes information easier to understand.

6.5.2 The participant's Relationship with Patients during the Consultation

NICE (2012 C) guidelines state that professionals should actively involve patients in discussions and enable them to make informed choices about their treatment in order to reflect its importance. This section explores this relationship.

In this category the results showed that participants were not very successful in negotiating agendas and initial relationships with patients, see (Section 4.4.1; Skills Section 1), and 73% of our participants did not use open and closed questions appropriately which enabled the participants to build up relationship with patients (4.4.5, Skills Section 5). However, this might imply that the participants feel that establishing a narrow relationship with a patient is acceptable at the initial treatment stage.

Participant 2: (12 yrs.; qualified; M): In terms of feedback from the patient, I didn't expect too much...So if I can get the information over in a fairly quick, fairly succinct way, but also not, you know, say right I've got your medication here. I've made you a cup of tea...but actually, I'm the boss, I'm in my environment, you're coming into my environment and I've got a job to do and I want to give you some information and you're to take that information.

The behaviour that the participants exhibited was not only about judging the needs of patient about anti-depressants. There was also less willingness to listen to patients' preferences. This might indicate that patients do not receive opportunity to discuss important matters with the participants.

Pharmacists and patients completed a questionnaire from multiple perspectives using an interpersonal perception approach assessing their perceptions of the benefits of pharmaceutical care (Assa-Eley and Kimberlin, 2005). In accordance with our findings, Assa-Eley and Kimberlin found 43% of patients agreed that their pharmacists are passive when dispensing prescriptions, but 22% of

patients said that their pharmacists usually ask them if they have any medical related issues when they issue repeat prescriptions. The patients had a prescription dispensed during the previous 6 months, and there may be some recall bias.

Furthermore, a study by Knox et al. (2014) finds that 66% percent of Australia patients do not speak with pharmacists about anti-depressants and other related health issues at all. Out of 22% of patients who do speak to pharmacists, pharmacists initiated two-thirds of these conversations. Patients were satisfied with services, but the author suggested that expectations about pharmacy services related primarily to technical service qualities. However, when participants described what they liked most about their pharmacy visit, functional qualities featured more frequently than technical qualities, this may mean that patient value the relationship behaviour and not only information given about the medications. This may contrast the previous argument (Section 6.3.2) when our participants felt that patients lack knowledge about the pharmacists' role, and do not know what to expect from of our participants. In contrast, in a study by Riley et al. (2013) pharmacists and nurses responded more positively to patients' concerns and cues than general practitioners did. 'Prescriber pharmacists' acquired skills and experience when interacting with patients; but this was in a more clinical environment than the typical community pharmacy. Our participants were still keen to build up relationships, but more at subsequent visits when they perceived the patients would be ready to communicate them. A cross-sectional study by Street et al. (2007) finds that practitioners who were more patient centred and had positive emotions toward patients were more active and showed better communication skills. The practitioners surveyed were unaware that patients who were not actively involved needed more assistance than the active patients. Indeed, Greenhill et al. (2011) supports these findings when they studied a group of pharmacists who did not demonstrate good skills to encourage patient participation. Perhaps patients had taken their medications previously and pharmacists thought patients were not ready to discuss them. Nevertheless, our participants were

less likely to engage with newly prescribed patients. Indeed when Hassell et al. (1998)

studied the nature of advice giving to patients, their results showed that pharmacists use unsolicited instructions and 'closed questions' when talking about medicines, and peripheral advice or further explanation is not always given. They characterise pharmacists' advice giving as being brief and directive about dosage and administration, and this indicates that the pharmacists were unwilling to meet their patients' needs.

Gordon et al. (2007) report that their study group of patients were not greatly involved in their treatment and physicians used a paternalistic approach. They also report that patients did not understand physician instructions because too much jargon passed between them, and physician responses were limited to the questions that patients asked. Some patients described situations where their questions received inadequate responses; but this study used audio recording and it is possible that patients showed different nonverbal behaviour, which may not be addressed in the study. Biddle (1986) reports that conflict forms when professionals find it difficult to perform their roles due to a lack of skills and inconsistencies that exist between expectations of the role and personal characteristics, and these circumstances create pressure for the individual. Indeed, in our study some participants adopted a paternalistic approach in order to avoid emotional situations and to maintain control. A patient centred approach equals a lack of control. This is supported by Sheridan et al. (2012) who report that among their study group patient interaction with physicians tended to be paternalistic in style rather than involving discussion, they felt a hierarchy of social and professional roles, the patients were elderly and possibly the physicians felt it difficult to involve them in decision making.

In a focus group examined by Guillaumie et al. (2014), the aim was to describe pharmacists' perceptions with respect to their practice and patients' anti-depressant treatments. Pharmacists were more likely to be directive at the first meeting with a patient when giving out information about anti-depressants, and would ask questions to obtain necessary information. The author used field

notes, which may be highly subjective. In consistence, Boeni et al. (2015) found pharmacist-patient interaction centred on advice about medication administration and dosage, and only 6% patients received counselling about adherence to their medications (concordance).

Knox et al. (2014) show that patients rate technical information less highly than the quality of the services they receive and that patients are eager to have a positive relationship with pharmacists. This supports the findings of Latif et al. (2011) who suggest that although MUR services provide pharmacists with an opportunity to demonstrate their competence, pharmacists often used closed questions when meeting patients. This means that patients often provide limited responses and are less encouraged to involve themselves in discussion (Latif et al., 2011). Patients were passive whilst pharmacists were dominant during consultations. The pharmacists demonstrated low levels of open questioning. The study 25% of pharmacies did not offer private consultations, and this might have contributed to the tendency of pharmacists not to use open questions during interviews. This may reminds us (Section 5.1.5) that the participants were less likely offer private consultation even though they were aware of the importance of this service. It appeared the decision to offer consultation room taken by our participants but not offering patients this service

Over half the participants used a paternalistic approach, while a minority (5) demonstrated relationship building with patients. Mahesh and Parthasarath (2004) explain that communication skills are at the heart of building relationships with patients, because good communication skills work to help patients understand health conditions and open up about their feelings during consultations. Empathetic communication helps to promote trusting relationships between pharmacists and people with depression. Our participants said successful providers are able to demonstrate a good attitude towards people with depression, and one not based on stereotypes. For example, Participant 9 said that a good attitude helps to create good perceptions among patients, and makes them feel welcome. The participants showed a keenness to build trusting relationship with patients and to understand their values. She

said that exhibiting empathy and understanding the feelings of patients is more likely to make patients comfortable and encourage them to talk about their situation.

Participant 9: (4 yrs.; qualified; F): Obviously you've got to be sympathetic, understand what they're going through. So you've got to show a bit of emotion. Yes I mean patients do feel like, as if, they, you know, they're been looked at in a different way as such but (sigh)...I just try to make them feel as comfortable as possible, make them feel cosy, and the most important thing out of everything I think is making them feel at ease.

However, Participant 15 also perceived that patients listen more to physicians' instructions rather than to pharmacist recommendations. This might be because patients visit the same physician on a regular basis, and this regularity helps to build trusting relationships. In contrast, visiting different pharmacists and different pharmacies does not promote the formation of good professional relationships.

Participant 15: (3 yrs.; qualified; M): They view it in the sense that, they take medicine based on trust in that the doctor has said I have depression. A lot of it is based on trust.

Indeed, regular patient visits to the pharmacy help to facilitate better consultations and discussions. Half of participants said that patients who visited regularly were more likely to receive information and advice about lifestyle. This indicates that accessibility to pharmacies can help build better professional relationship with patients. Participants said that patients are more likely to be open to sharing and receiving information during a second visit. This is because patient symptoms are beginning to be resolved and, thus, the patient is in better health. The participants implied that second visits promote relationships with patients and provide an opportunity for the discussion of the management of patient treatments.

Participant 3: (15 yrs.; qualified; F): So patients that you've seen a couple of times, that you can see, are a little bit brighter, and if somebody's higher up already, that we're talking about building up enough energy, because at that second one is where I'm like, right come on, is it working, is it not?

Bentley, et al. (2005) find that pharmacist attire matters less than the caring and listening skills and levels of respect a pharmacist has for a patient. There were higher levels of patient satisfaction for inter-personal skills over attire on patient evaluations. Kielmannet et al. (2010) find that establishing trust and promoting good relationships results in higher levels of patient satisfaction, which, in turn, helps patients become more motivated to manage their condition independently. Furthermore, Crump et al. (2011) find that empathetic and trusting relationships are important to clients, and are the basic framework for delivering successful care. Crump et al (2011) also find that pharmacists should articulate advice to patients in a style that does not overload them, and that matches the patient's ability to understand and process information.

In a study by Hamoudi et al (2011), 52% of patients in the United Arab Emirates trusted pharmacists to provide pharmaceutical consultations and 55% regard pharmacists as their friend. These results are promising and show that pharmacists who seek to offer consultation are able to gain patients' trust and promote the role of the pharmacist generally. However, this study focuses on the more technical aspects of handing out information, and the authors do not prove whether good consultation alone can improve patient satisfaction.

The participants showed a paternalistic approach and less engagement of patients in open discussion. Qualitative and quantitative findings agreed that participants did not (sufficiently) build up relationship with patients. Participants were, however, aware of the importance of building relationships when gaining the trust of patients and facilitating patient comfort. This reason for this discrepancy is more likely to be difficulties building relationships during a first visit, whereas regularity helps both patients and the participants to promote

therapeutic relationships. A study by Carter et al. (2015) finds that implementing a structural equation model (SEM) (Listening, Outcomes, Communication efficacy and Willingness) encourages patients to re-use the Home Medicine Review service, and this has a direct and indirect impact on patients. This implies that listening to patients enhances positive outcomes (the evaluation) and communication efficacy (indirect), and encourages a willingness (direct) to re-use the service. Moreover, taking direct action improves patient perceptions about pharmacists listening and enhances their willingness to engage regardless of whether they perceive positive outcomes or feel confidence.

Receiving attention during medication management interviews can help to facilitate the patient's decision about whether or not to persist with the services. White et al. (2012) find that the Home Medicine Review encourages pharmacists to develop good relationships with patients. In this study, a semi-structured focus group assessed consumer perceptions of the Home Medicine Review. Many participants said that the HMR improves relationships with their pharmacists because the pharmacist gives them more attention and spends more time with them. Patients said the HMR gives them an opportunity to raise concerns and ask questions.

The above explanation implies that good communication with patients is important. However, regularity facilitates successful relationships with patients. The approachable manner of pharmacists and open access to pharmacies needs improving.

6.5.3 The Follow-Up Service

The Pharmacy Guild of Australia (2010) claims that the first point of call for patients seeking medical advice is the pharmacy and the Royal Pharmaceutical Society (2015) suggest that improving pharmacist provider services may enhance patient adherence to medications and promote maximum efficacy.

Participants said that the accessibility of pharmacies generally provides advantages over other care settings, where (most often) booked appointments meet health care professionals. Participants said that meeting patients regularly enhances patients' awareness of the availability of services in the pharmacy, and this might encourage patients to seek help from the pharmacist. For example, Participant 3 mentioned that patient motivated action also encourages the pharmacist to dedicate more time to better patient care. Reduction of the symptoms and willingness of patients to collect their medications probably encourages the participants to provide more information about lifestyle.

Participant 3: (15 yrs.; qualified; F): So patients that you've seen a couple of times, that you can see, are a little bit brighter, and if somebody's higher up already, that we're talking about building up enough energy, because at that second one is where I'm like, right come on, is it working, is it not?

Although accessibility is an advantage, this means that pharmacists are, sometimes, involved in work outside of their boundaries. The participants said that patients might visit their pharmacies to ask for interpretations of clinical tests when this role was part of the job of the physician. Moreover, they said some patients request medicines without consulting their physicians, as noted by Moja et al. (2013). Mehralian et al. (2014) find that the attitude of the pharmacist transforms when they gain an awareness of the community they work in, through knowledge or experience. Mehralian et al (2014) find that pharmacists in Iran lack professional status in society in comparison with other health care professionals. This may imply that some pharmacists cannot easily create a professional image for themselves in comparison to that enjoyed by other health care professionals in their communities. AbuRuz et al. (2012) explain that many pharmacists think that lack of access to patients is the major barrier to providing good pharmaceutical care.

Pharmacists often provide advanced services which include medicine reviews (MURs) aimed at enhancing the patient's knowledge of their medications in

order to make sure the patient is using medicines appropriately and to address patient concerns (Pharmaceutical Services Negotiating Committee, 2013). Participant 17 raised the question of obtaining the opportunity to open-up discussions with patients. He said that a good relationship with the patients is the key for opening up consultations.

Participant 17: (5 months.; qualified; M): Well we do tend to do that but that's normally in a MUR setting – medicine use review and we sit down with the patient, we talk about those sort of questions but realistically and in reality that is what happens unfortunately.

Participant 17 thought that this service is for people who take medicines for physical diseases, but he is prone to taking this opportunity to discuss adherence to anti-depressants. The participant said that a planned 'MUR' meeting encourages patients to disclose their health issues. Some participants in the current research claimed they did not always have enough time to help every patient, and that when they do dedicate time to patients this is more likely to be planned time rather than ad hoc time. Indeed, McDonald et al. (2010) find that pharmacists undertaking MURs often experience interruptions from another staff member. This is mainly because it is important for the pharmacist in the dispensary to check prescriptions. Therefore, time dedicated to MUR often means less time for other activities. Although the MUR service is an opportunity for pharmacists to demonstrate their competence, pharmacists often use closed questions when meeting with patients. In Australia, McMillan et al. (2014) find that many participants with chronic disease are unaware of and do not receive the Home Medicine Review. However, the responsibility of the pharmacist is to enhance a patient's awareness of health care services that can promote a better quality of life.

6.6 The Satisfaction of Patients with Services Provided

Continuing Professional Development (CPD) (see Section 4.6) involves a learning activity that encourages pharmacists to reflect after observation. The

majority of the participants who engaged in our study said it was their intention to try to build good relationships with patients, and a key part of doing this was establishing trust. Trust happens by opening up consultations with patients and encouraging shared negotiation. However, this kind of learning activities does not always help to increase patient satisfaction. A longer period of activity was needed and repeated feedback might improve their practice. Wiedenmayer argues that it is not only important to try to improve the skills and attitudes of pharmacists through training, but also to implement this training in daily practice (Wiedenmayer et al., 2006). Indeed, pharmacists often lack time to achieve the goals of CPD (Power et al., 2008).

It might be the pharmacists' personal intentions influence motivation to change. There are many processes for individuals to pass through to change their behaviour. In the pre-contemplative/unaware stage people are not interested in change, cannot see the need to change, and have no intention of doing anything differently and are not aware that their life could be better. Contemplative is the stage in which individuals intend to change in the next six months. Individuals begin to think about concerns and the possible need to make some changes. They recognise that there are issues and that they can and should do something about to make their lives better (Miller, and Rollnick, 2002) It may be that the satisfaction of patients did not increase because our participants are more likely to respond to workload, and are less likely to dedicate enough time to patients. This includes offering fewer private consultations to patients. Patients were dissatisfied that the pharmacists did not offer privacy, and this finding is supported by Chong et al. (2013 A) who state that less than half of patients are offered a private room and that pharmacists are more likely to deal with patients at the dispensary counter. Time constraints are the greatest barrier to facilitating good communication with people with depression.

In our study, patients were less satisfied with pharmacist performance possibly because the participants were concerned about crossing professional boundaries and because the participants were not proactive in their behaviour. This supports a study by Morken, et al. (2008) which finds that role conflict is

a barrier to self-efficacy and that role conflict negatively influences the ability of pharmacists to counsel patients. However, Fleming et al. (2015) find that patients who have less expectations of the pharmacist accept less intervention by pharmacist. The study also finds that patients who lack familiarity with medication therapy management services do, at some stage, intend to ask their pharmacist about the management of medications. Tarn et al. (2012) find that patients view pharmacists as experts on medication rather than support services, but that patients often ask pharmacists about the appropriateness of the medications GPs prescribe. The patients said that pharmacists play a key role as intermediary between patients and physicians. However, this study does not address mental illness.

Qualitative findings show that our participants give out information about anti-depressants and side effects, and the few of them who do this are motivated to respond by patient cues. Furthermore, the results show that the participants do not use teach back when dealing with patients and prefer to rely on one way conversations and are less likely to check patient understanding, see (Section 4.4.3; **Figure 4.12**); but this makes patients less satisfied. Just over half of patients said they were happy with the advice given about the proper use of medications, and less than half said they were aware of treatment related needs. These findings are supported by Chong et al. (2013 A) who conclude that pharmacists mainly provide advice about the safe and effective use of anti-depressants rather than try to understand the patients' medical conditions, or give out other non-medication advice for depression. AbuRuz et al. (2012) find that although community pharmacists have a positive attitude towards providing pharmaceutical care in Jordan, they needed more training; 80% of pharmacists are worried about their skills but not about knowledge they possess.

There are many reasons why our participants were less willing to provide good service to patients. Zanna and Rempel (1988) said that the attitude is influenced by many cues including: cognition (knowledge), feeling (stigma) and past behaviours (reluctant patients). According to self-efficacy theory, beliefs provide the foundation for human motivation and personal accomplishment; unless

people believe that their actions can produce the outcomes they desire they are less likely to perform them (Bandura, 1995). This may indicate that our participants had low levels of interest to manage depression and lacked skills. This discouraged the participants to place the patient at the centre of the consultation. Social cognitive theory states that behaviour, personal factors and environment factors may have an impact on willingness to provide service to patients. It is possible that our participants feel that the owners of the pharmacy encourage them to sell medications rather than offer cognitive advice (Bandura, 1991).

Learning and cognitive theory states that many different approaches influence people to change their behaviour, for example reinforcement, incentive and exposure. This may be associated with our finding that the participants are less likely to engage with people with depression due to lack of training (reinforcement) and they did not have time to offer consultation, while they were more willing to offer profitable services (incentives), and from participants past experience patients were not interested to learn from our participants (exposure). These determinants may make our participants feel low level of motivation (Ogden, 2012).

6.7 Summary of Themes

The synthesis of data revealed issues concerning the practices of the participant pharmacists.

The knowledge held by the participants about anti-depressants was satisfactory, and the participants demonstrated that they knew about the management of anti-depressants. However, it appeared that the participants prioritised giving advice about the effectiveness and safety of anti-depressants over providing information and advice about lifestyle. The results obtained by means of consultation observation and using the self-styled questionnaire support these findings. The quantitative data showed that our participants held

positive attitudes towards people with depression. However, the participants did not demonstrate a multi-faceted approach, and were more likely to hold negative views toward the management of patients' medications. Both the qualitative and quantitative results show that the participants think antidepressants are not as safe as other social treatments that may make management of people with depression harder. It is more likely that the participants did not possess enough confidence to engage with patients effectively. The participants felt they found it more difficult to engage with people who had mental illness in comparison with those who had physical diseases.

Another issue of current practice was time restrictions in the pharmacy. Often, the patients did not have enough time to dedicate to patients. The quantitative results show that patients were not satisfied with the amount of time the participants spent with them and patients indicated that they would be more satisfied if they had more time with the participants. The participants explained that, sometimes, they were not able to spend time with patients due to other responsibilities in the pharmacy, including undertaking work that contributed more directly towards pharmacy profits. This negatively influenced the motivation of the participants to provide additional services and to offer consultation services. However, the participants were often aware that they lacked time to spend with patients and expressed concerns that this approach might add to feelings of stigma experienced by patients.

Other participants felt that their role was ambiguous and that they were not aware of some of the responsibilities of their extended role. Furthermore, the accounts given by the participants showed that they lacked training for talking to patients about depression. The participants felt that they needed extra training to deal with patients with depression, and these comments were consistent with the findings of the observations where the participants did not demonstrate adequate skills for engaging patients into conversation, and the participants were reluctant to initiate consultations. Difficulties engaging with patients properly did not only occur due to a lack of training or a lack of time. Another

factor that affected the performance of the participants was a lack of collaboration with other health care professionals, due to concerns about professional conflict. Both patients and participants were more likely to defer to the authority of the physician, even when the patient and/or the participant had concerns about medications.

Additionally, the lack of a follow-up system negatively influenced the ability of our participants to understand their patients and this presented challenges when attempting to promote patient wellbeing. Not knowing the medical history of patients meant that the participants were not able to tailor advice as effectively as they wanted to. The participants were concerned that they might give out information that was not relevant to the patient, or that the patient had anti-depressants for other conditions. Not knowing the medical backgrounds of patients meant that it was more difficult to undertake valuable consultations because pharmacists did not tailor information to patient needs.

Although the participants claimed that they tailored information to suit individual patient needs, it became apparent that only a few participants actually did this. These results were consistent with the observation sessions with simulated patients. Overall, the participants were not confident when trying to individualise information given out to patients, and the participants used a paternalistic approach, rather than encouraging mutual discussion with patients. The participants did not try to build rapport with the patients and were more likely to follow their own agendas rather than prioritising the agendas of patients. The participants chose to focus information on guidelines about taking anti-depressants rather than offer lifestyle or non-drug related advice.

The majority of the participants did not practice using open-ended questions and did not implore patients to share information. Moreover, the participants were not very responsive to patient cues, and relied on the physician to gain the trust of patients. This approach negatively affected the ability of the participants to gain the trust of patients because it reinforced the primary authority and trust relationship between the physician and patient, rather than encouraging a similar relationship between the pharmacist and the patient, and emphasised

a discrepancy between patient and participant expectations. Our participants were most likely to make decisions on behalf of the patients. A variety of factors, including organisational barriers; a lack of training; a lack of confidence among the participants; time constraints; and perceptions about professional conflict meant that the participants were not able to put patients at the centre of a consultation. These factors served to reduce the motivation of the participants to provide a service that satisfied patient needs.

6.8 Implications of the Research

6.8.1 Investigating and Understanding Pharmacist Behaviour

The study aimed to explore the current practices of the participant pharmacists and provide an opportunity for the participants to reflect on their practice. The use of multiple methods in this study ensured the validity and reliability of the study. The combination of methods used provided rich data, and the use of self-reporting, interviews and observation revealed the intentions and actions of the participants when communicating with people with depression. The comparison between different themes discovered provided a greater understanding of the data collected.

The study found that the participants were able to maximise the efficacy of antidepressants and reduce side effects. The accounts of the participants gained via interview, and through observed consultations, indicated that the participants had a good understanding of patient medications and that they could enhance the expectations of patients. However, the attitudes shown by the participants towards providing additional services were not as impressive as the pharmaceutical knowledge they possessed.

The attitudes of the participants influenced their behaviour when dealing with patients in the pharmacy. This was evident from their audio-recorded accounts and the self-reporting questionnaires completed. The results showed that the participant pharmacists were less inclined to provide services associated with

the extended role of the pharmacist, and, in some situations, the participants did not offer consultations because of the beliefs they held. Overall, the participant pharmacists showed a positive attitude towards people with depression but a negative attitude towards carrying out the extended role of the pharmacist.

Audio recording proved to be a good tool for collecting the participants' opinions about patients and the services provided in the pharmacy. Furthermore, the recordings demonstrated that the participants were less likely to interact with patients who had mental illness. When dealing with people with depression, the participant pharmacists found it difficult to make decisions to open up the consultation. This may imply that they need to gain a greater understanding of mental illness and undertake further training in order to improve their attitude and approach. The links made between themes provided a rich summary of the approaches used by the participants.

Another finding of the study was that the participant pharmacists often lacked time to dedicate to patients in the pharmacy, due to heavy workloads. This meant that patients were less likely to raise their concerns. Furthermore, organisational barriers, such as the varying skills mix between staff working in the pharmacy, also contributed to feelings of stigma experienced by patients. Patients sometimes gained a bad first impression from other pharmacy and non-pharmacy staff working in the pharmacy (such as till servers and assistants). One solution to this problem would be for all staff working in a pharmacy to receive training about how to deal with patient customers. Only a few participants acknowledged that they checked whether a patient understood the information given out, and the interview and observation sessions revealed that the majority of participant pharmacists did not check to verify whether a patient had understood information given out.

One drawback of conducting interviews or observations is that people may change their behaviour or modify their opinions. However, in this research it became apparent that the participant pharmacists did not decide to change their behaviour from normal, and they appeared to provide consultations to the volunteer patients as if they would usually do in a real pharmacy. This finding

may imply that the participant pharmacists were comfortable and so did not feel the need to change their agenda. The application of the (MRCF) model suited the methods of observation used in this research. This model was useful and detailed enough to distinguish between the specific skills that the pharmacist uses. Nevertheless, some pharmacist skills rely on collaboration with physicians and other health care professionals in order to involve patients in their treatment plans.

Overall, the methods used in this study assisted a successful approach towards gathering detailed data about pharmacist-patient communication during consultations, and the same methods could be used in future studies which aim to investigate pharmacist communication skills.

6.8.2 Developing Pharmacist Training

The participant pharmacists acknowledged that they lacked training about engaging with people with depression. Some of the participants were not confident enough to place patients at the centre of the consultation. There is the possibility that the participant pharmacists used the excuse of not having received enough training as a way of reducing negative perceptions of them when they showed poor communication skills. Alternatively, these participant pharmacists might have mentioned that they lacked training because they genuinely wanted to bring this issue to the attention of the researcher and because it would help them practically when encountering awkward situations. Although governments have set out policies to increase the responsibilities of pharmacists, there is still little available pharmacist training that specifically deals with the issue of mental health. However, this lack of formal pharmacist training may also contribute towards patients never becoming fully aware of the extended role of the pharmacist.

A lack of collaboration with other health care professionals and with other health care systems made the participants feel isolated professionally. Although the pharmacists who took part in our study had differing levels of experience

working as community pharmacists, the data showed that a greater level of experience in the job did not necessarily correlate with increased confidence when dealing with patients with depression. This indicates that training at university incorporated early on in the training of pharmacists might be of value. Continuous learning (CPD) should also form an important part of ongoing training, as well as self-reflection for dealing with people who have mental illness. Patient feedback would also prove useful as part of initial and CPD training. The simulated patients were not shy to provide feedback by means of the questionnaire and did not appear to modify their answers to favour their pharmacist. This helped the researcher to collect rich data about the decisions made by the pharmacists to offer consultations, and during the consultations held with patients.

Additional training as part of CPD would be valuable, but targeted specifically at dealing with people with mental illness and/or depression in order to meet patient needs. Furthermore, time-management or time-effectiveness training may be useful in order to help pharmacists meet the challenges they face when trying to prioritise patients, especially when they have other tasks to fulfil. The MRCF model demonstrates that this kind of training can be implemented into further research and teaching.

6.8.3 Improving Pharmacy Practice

The study found that possessing good communication skills are essential when trying to build effective relationships with patients. This includes building good relationships with patients at initial consultation stage and during a consultation. Building good relationships helps pharmacists to deliver quality and tailored advice confidently. Moreover, building good relationships enhances the patients' willingness to receive information because good communication skills help to build relationships of trust. As previously discussed, pharmacists perceived that their patients had more trust in their physicians, and that their patients were

more likely to follow the advice of physicians concerning drugs, than the advice given by the pharmacist.

However, in addition to communication skills, other factors influence the trust between the pharmacist and the patient, such as the familiarity the patient has with the pharmacist, the service and the pharmacy. All these things contribute towards the success a pharmacist has when approaching a patient in order to try to meet their needs. The pharmacists mentioned that patients sometimes lack an awareness of the professional abilities of the pharmacist, and this lack of awareness made it more difficult for the pharmacists to establish good relationships with their clients.

Our study found that, overall, the participant pharmacists failed to offer privacy to patients with depression when they came into the pharmacy, and this is, possibly, another reason why the participant pharmacists failed to establish a good relationship of trust between themselves and the patients. However, the general environment of the pharmacy makes it less possible to offer privacy in comparison to other health care settings, such as the physician's surgery, for example. This is why it is so important for pharmacists to use a private consultation room if one is available, because this helps to create a comfortable and confidential environment for patients to discuss their concerns. In this way, the patient feels respected. The patients questioned in our study said that privacy meant that nobody could overhear conversations taking place in the dispensary area. They felt that the dispensary was a place for selling and that the consultation room was where professional work took place. The value of a consultation room is that it can help to reduce the stigma felt by patients, and provide a welcoming environment.

The participant pharmacists in our study mainly used one-way communication methods that did not encourage patients to express their agendas. In the structured consultations used in our study, the participant pharmacists were more likely to display paternalistic behaviour, and they did not give patients the opportunity to share their concerns (6.5.2). In turn, patients were not able to

raise concerns about their medications. This paternalistic approach reduced the likelihood of patients adhering to medications. The patients looked for other treatments to fit in with their lifestyles and reduced their symptoms, and one of the best ways to ensure this set of circumstances is to encourage pharmacists to engage with patients in mutual sharing in order to optimise the benefit of medications.

6.9 Future Work

The results found that the participant pharmacists experienced time constraints when working in their pharmacies, and this affected their communication style and performance. Future studies might wish to observe and compare communication styles using a simulated patient scenario covering both conversations held at the dispensing counter (in the presence of other people), and those held privately in the consultation room. This might provide feedback to the pharmacists about the feelings of the simulated patients in both situations (when they receive advice in the consultation room and at the dispensary).

Another suggestion for further study is monitoring the documentation completed by the pharmacist during consultations, including computerised record input and/or manual entries in a diary. In our study, when the participant pharmacists asked patients about their medical histories, they mostly relied on memory to construct consultations and this did not help when they were trying to build rapport with patients. Sometimes they forgot what patients had previously told them. Written and computerised record keeping is essential in pharmacy practice, but it is also possible for pharmacists to become distracted from keeping accurate records, and this is another area worth investigation. This study identified the MRCF model as applicable for assessing pharmacist-patient consultations. It is a valid model and it suited the pharmacist led consultation sessions, unlike other models that have a rigid design for the study of physicians, and their skills.

6.10 Strengths and Limitations

As with any other research, there are several limitations to this study. The sample of the pharmacist participants recruited to take part in the qualitative study were not necessarily representative of the wider population, because the research aimed to collect rich information connected to the profession of community pharmacist. The community pharmacists recruited to the study expressed a wish to enhance their practice in areas such as offering consultation services, and as part of the study, the pharmacist participants were responsible for recruiting patient participants. However, this approach opened up the research to bias because the pharmacists were freely able to recruit patients with whom they have good relationships, and who may have favourable views of the services offered by the pharmacists.

The researcher had difficulty recruiting pharmacist participants. When piloting the study, this problem did not occur, but upon commencement of the actual research, it was difficult to recruit the required number of pharmacist participants, even when the researcher sent out emailed invitations to many people, and to different community pharmacies. This posed a problem because the researcher had a limited amount of time to conduct the research. However, sending out emailed reminders and expanding circulation of the invitation email to different pharmacies helped to solve this problem.

Overall, the pharmacists who took part co-operated with the researcher in order to dedicate time to assess the questionnaires prior to starting the recorded mock pharmacy sessions, and they were punctual in attending the sessions. However, some pharmacists did not want to participate in the study for a number of reasons, including a lack of time and nervousness due to the process of recording and observation. None of the pharmacists approached indicated a lack of interest in the study, and put forward other reasons for not wishing to take. Difficulty experienced engaging pharmacists in this kind of research have been reported by other researchers (Mehralian et al., 2014). Previous researchers note similar reasons for non-participation. The exact reasons why some pharmacists are reluctant to take part in research is unclear, and can be

due to a variety of reasons, including a lack of interest, being busy, or lack of remuneration, but these are inevitable barriers.

The participant pharmacists did not find it difficult to recruit patients to complete the before and after intervention questionnaire, mainly due to the high number of people suffering from depression who came into their pharmacies. Pharmacists chose patient samples according to convenience rather than in a random fashion, and this system of choosing is one of the limitations of the research. This system of choosing has the potential to introduce bias into the research, because the pharmacist may well have chosen patients whom they felt might give them a favourable review.

The study combined a quantitative and qualitative approach in order to ensure robustness and strength, and to facilitate a thorough exploration of the opinions and perceptions of the patients. The use of different methods enhanced validity and reliability. As previously discussed in the chapter dealing with methodology, the presence of a researcher during the recorded consultations may have influenced the behaviour of the pharmacist participants. It is possible that the participants tried to perform at their best, and/or displayed particular characteristics due to the presence of the researcher. Furthermore, the participants may have felt nervous because they were being audio recorded, and this might have affected their behaviour. Prior to starting the mock pharmacy sessions, the researcher spoke to all the participant pharmacists to explain the benefits and aims of the study, and in order to build up a rapport with the participants in order to make them feel more comfortable. Furthermore, ensuring the comfort, confidentiality and agreement of the patients who took part in the research was also important.

The researcher in this study did not have any direct contact (in the role of pharmacist) with the patients during the consultations. Instead, the researcher worked out in the pharmacy to make some noise similar to the real pharmacy. The same researcher conducted all data collection and analysis throughout the study, so that there were, therefore, no problems with inter-researcher reliability.

However, this situation can serve to introduce an element of bias, based on the thoughts and ideas of the researcher, and so a volunteer supervisor checked the coded data to enhance reliability and check for researcher bias.

The study collected a large amount of valuable data. A large sample of patients took part, totalling 160. This provided substantial and valuable data about their experiences and levels of satisfaction with the services provided by the participant pharmacists. As part of the experience questionnaire, the patients indicated that they wanted a greater degree of mutual shared decision making to occur between themselves and the pharmacists, this occurred when patients less satisfied with the provision of the pharmacists, possibly it was found only of patients who were generally satisfied from the services received by pharmacists.

The sample size of participant pharmacists was small, totalling 22 pharmacists, but the data obtained indicated that audio recording the pharmacist's opinions was a reliable method to adopt in addition to the use of patient self-reporting. The data collected showed that the pharmacists had good knowledge about the effectiveness and safety of anti-depressants, but data collected about attitudes indicates that the pharmacists need to modify their views about certain aspects of depression and their behaviour towards patients in order to meet the standards of NICE guidelines. Overall, the participants demonstrated a positive attitude towards depression, but were not able to translate these beliefs into good service practice.

This is the first study to enable a comprehensive analysis of the services community pharmacists provide to people with depression. As part of the research, participants were able to reflect on their current practices when using the MRCF (3.3.8). Previous research uses models for consultation designed for physicians, but for this study employs a model designed for pharmacists. Furthermore, the accounts obtained from the pharmacists using audio recording facilitated an in-depth analysis and revealed the many challenges that community pharmacists face when dealing with people with depression.

6.11 Conclusion

In this study, the participant pharmacists showed they had substantial knowledge about anti-depressants and were able to provide information about anti-depressants to patients. The pharmacists were able to answer patients' questions concerning their treatments, and, in order to set the scene for the consultation, all of the pharmacists asked patients about their reasons for taking medications and about the patients' experiences with their medications. This initial engagement was one of the strengths of the participant pharmacists. However, although the majority were keen to give advice to patients about anti-depressants, very few were interested in trying to raise patients' awareness of social and lifestyle treatments. It is more than likely that the pharmacists held prejudices about people with depression, and this influenced the pharmacists' willingness to provide additional support. In the study, the pharmacists failed to take proactive behaviour, and, so, patients were less involved in the consultation. The current study proves that patients are most likely to collect their medications from the pharmacy (which may be located far from their home) and they do not linger talking to pharmacists in the pharmacy. However, this behaviour does not give pharmacists the chance to initiate conversations about the quality of care, and it encourages pharmacists to be judgemental about the needs of patients.

The participant pharmacists experienced time constraints and so were not able to give enough time to patients. This approach served to enhance perceptions of stigma among patients. Furthermore, adequate liaison with other healthcare professionals did not take place for a variety of reasons, including the inability of physicians and patients to perceive the extended role of the pharmacist. This led to hierarchical conflicts and low expectations from patients. In turn, this affected the participant pharmacists' style of communication. It is more than likely that collaboration with other healthcare professionals can enhance patients' expectation about the pharmacist's extended role, especially if pharmacists need to work with patients and physicians to design treatment plans for patients. The participants in this study lacked self-efficacy when consulting people with depression and lacked the confidence to open up mutual

discussions with patients, and this led to discrepancies in expectations between pharmacists and patients about individual responsibilities.

Pharmacists encounter many challenges when communicating with people with depression. The balanced use of closed and open questions is crucial to pharmacists' effective communication with patients and for building good pharmacist-patient relationships. This balanced approach helps to make the patient comfortable and more confident to discuss certain subjects with the pharmacist. Building good relationships enables the pharmacist to encourage patients to form and communicate agendas, and enhances patient expectations of the abilities of pharmacists. Building good relationships is also important for improving pharmacists' awareness of the responsibilities of their extended roles. However, pharmacists must take care to ensure the privacy of patients.

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Appendices

Appendix-1: Anti-depressants Medications for Treatment of Depression

Class of anti-depressants	Date of Introduction	Type of side effects
Selective serotonin reuptake inhibitors (SSRIs) (Healy, 1997) e.g.: Sertraline and Citalopram	1987	<ul style="list-style-type: none"> • Sexual effects • Gastrointestinal effects
Serotonin and noradrenaline reuptake inhibitors (SNRIs) (Beck and Alford, 2014) e.g.: Duloxetine and Venlafaxine	1993	<ul style="list-style-type: none"> • Increase blood pressure • Nausea • Dry mouth
Tricyclic antidepressants (TCAs) (Beck and Alford, 2014) e.g.: Imipramine and Desipramine	1957	<ul style="list-style-type: none"> • Slight tremor • Fast heartbeat • Constipation, sleepiness
Monoamine oxidase inhibitors (MAOIs) (Beck and Alford, 2014) e.g.: Phenelzine and Isocarboxazid	1957	<ul style="list-style-type: none"> • Dry mouth • Nausea, diarrhoea or constipation • Headache • Drowsiness • Food interaction

Appendix-2: Self-help Charities Signpost

Title	Online address
1. Centre for Mental Health	http://www.centreformentalhealth.org.uk/
2. MIND	http://www.mind.org.uk/information-support/legal-rights/clinical-negligence/
3. Mindfulness	https://www.mentalhealth.org.uk/a-to-z/m/mindfulness
4. Rethink Mental Illness	https://www.rethink.org/about-us
5. SANE	http://www.sane.org.uk/how_you_can_help/sane_community/

Appendix-3: Search Strategy

In the current study the researcher focused on four databases: Web of Science, PsycINFO, Medline and the Cochrane Library. Web of Science, PsycINFO and Medline are databases where primary research is indexed. The Cochrane Library is associated with systematic and meta-analyses, which explore the answer to precise questions in critical appraised articles. The search terms used in these databases included both free text terms and thesaurus terms (e.g. MeSH). The free text terms were used with truncation; while the thesaurus terms (as suggested by the subject librarian) were used without truncation. In PsycINFO the terms used were: (pharmacist* AND MM "Communication Skills" OR MM "Language Proficiency" OR MM "Rhetoric" OR MM "Writing Skills" AND MM "Major Depression" OR MM "Dysthymic Disorder" OR MM "Endogenous Depression" OR MM "Postpartum Depression" OR MM "Reactive Depression" OR MM "Recurrent Depression" OR MM "Treatment Resistant Depression") (depress* OR antidepressant* OR anti-depressant* AND pharmacist* AND communication*). The search terms in Medline were: (depress* OR antidepressant* OR anti-depressant* AND pharmacist* AND adheren* OR complian* or concordan*). The Web of Science terms used were: (community pharm* AND consultation AND willingness) (Attitude AND knowledge AND pharmacist AND depression) (communication* skill* AND pharmacist* OR pharmacy OR pharmacies) AND (depress* or antidepressant* or anti-depressant*). (Pharm* AND confidence* AND depress*) (Pharmacist and communication skills and consultation) (Pharmacist AND consultation AND depression). In the Cochrane Library the terms used were: pharmacist* AND (depress* OR antidepressant* OR anti-depressant*). All these searches identified 153 articles and 2 systematic reviews. Of these 153 articles, 23 were fully reviewed because they are relevant to the current research. All studies published in databases were included except those based only on personal experience and non-English studies if they were not translated to English. Furthermore, thesis and books were included. Randomised controlled studies were chosen if they were relevant to the current research project and relevant to the United Kingdom's context, e.g. European studies. However, studies conducted in Middle East countries (whilst counter-cultural) enable us to make comparisons with the United Kingdom and were used. Survey methods were included, for example to assess the attitude of the pharmacist in the pharmacy. This type of study is relevant to one This type of study is relevant to one objective of current study i.e to assess the attitude of pharmacists in practice.

Appendix-4: Meeting Conducted with People who had Depression in 'Mind'

I met with recovering people in 'Mind', which is a medical charity aimed at providing advice and support that empowers individuals experiencing mental health problems. The aim of the meeting was to engage these people as collaborators in developing our study, and enhance awareness of the patient's requirement concerning health care services. One of the assessment tools for the services provided to the patients was a satisfaction questionnaire, which is used in the current research. This assessment tool provides a view about the extent to which people with depression are satisfied with the 'consultation' service provided by the pharmacist. Some of Mind members raised their concern about pharmacists not being helpful and not showing proactive behaviour to help patients. Rather, they viewed the pharmacists as just a dispenser who tended to be busy and avoided helping the patients. Even though the pharmacist was available to help the patients, sometimes the patients were likely to be nervous to ask him or her anything. They would also think the pharmacist was not interested in delivering health care services. Many of the patients revealed not knowing about the pharmacy consultation room and wondered whether the room was actively used for pharmacy consultations. They stated that they perceived high stigma and were not happy to ask the pharmacist for a consultation or for any advice. Moreover, having some symptoms of depression and having negative moods associated with this played a large impact when asking the pharmacist for help. They stated that the issue of not knowing what the pharmacist could offer, this attitude reduce their expectation of services pharmacists could provide. This issue of pharmacists not offering a consultation service to patients, was not only associated with new patients visiting the pharmacy for a prescription, but also with regular patients who visited the pharmacist for refilling prescriptions, without being asked if they were happy with the medication. In addition, pharmacists did not ask the patients for any signs of improvement they had. This could add to their concern that the pharmacists were not interesting in monitoring and managing them. Some of these patients take many medicines at the same time, and have growing concern whether they will receive medication that will work well together.

Appendix-5: Informal Interview with Practitioner

Interview with J T

I met with J T, Pharmacist and Participant 2, on the 17 August 2015 to ask him some questions about how he deals with patients with depression who come into his pharmacy. The interview covered what kind of information he provides about anti-depressants, his communication style, and what skills he uses when he talks to people with depression.

1. Initial Communication with the Patient

He said that he tries to focus on patients who have recently been prescribed anti-depressants but he also tries not to forget repeat prescription patients. He always asks patients 'Are you OK?' He said he is keen to meet with newly prescribed patients personally, rather than leaving them to be dealt with by another technician. On first meeting a patient, the first thing he does is to find out if the prescription relates to the person he is speaking to, rather than someone else. Then, if he is speaking to the patient themselves, he will offer a consultation.

2. Communication with the Depressed Patient

He said that he prefers to invite patients for a consultation rather than insisting on having one in order not to inflame the temper of patients or to trigger symptoms which might prevent the patient from accepting the offer. He said that the patient needs to be willing to listen in order to elicit a positive result. If the patient feels reluctant to engage in a consultation then said he tries to find an opportunity to give out important and basic information to the patient about their course of treatment. He said this helps to build trust for when the patient comes to the pharmacy again. said that, in his experience, patients remember critical pieces of information supplied to them and this information can be used to good effect on their next visit.

He explained that if the patient shows no co-operation then he will try to be as accessible as possible so as to encourage them, on some level, to be able to enquire about problems and obstacles comfortably in the future. Also, He said that some issues need the patient to be able to collect their thoughts between their first and their next visit in order for a positive outcome to be achieved. He said that the next patient visit might be better than the first visit, and this helps him to be able to bridge the gap and to offer a consultation that will be accepted. The aim is to help the patient to understand the necessity and goals of a consultation in order to optimise treatment for those who take anti-depressants.

3. The Use of Non-verbal Contact (Such as 'Eye Contact')

He observed that some of the newly prescribed patients look worried when they first visit the pharmacy, so he uses eye contact to create a rapport with the patient and to try to ascertain whether the patient is trying to seek help, and this helps him in his professional work and to communicate with the patient efficiently.

4. Initial Communication between the Pharmacist and the Patient when Dispensing

He said that he identifies himself to the patient and asks 'Are you Ok' in order to get the patient's attention so he can evaluate the patient's responses quickly. Then, this contact is used in order to frame advice and to offer a consultation. He said that he feels that posture and gestures are important when standing at the counter and that he changes posture and uses gestures to convey openness or to indicate there is a private room to talk in. This helps him to communicate that any information shared will remain private and confidential, should the patient wish to use the consultation room.

5. The Reflections and Responses of the Pharmacist

He explained that some clients are shy when visiting a new pharmacy. He said, 'Some patients say that they usually pick up prescriptions from a pharmacist that is far away from their home.'

He said that picking up on these kinds of messages helps him to establish whether the patient is shy or feels any stigma. If he feels that the patient lacks important information, has not had a consultation before, or shows concerns and fears, then he will offer a consultation. He said that patients often visit pharmacies further away from home so that they are not recognised by others locally.

6. The best ways of communicating with a patient when providing a consultation: He said it was important for a pharmacist to use empathy particularly with new patients and to convey knowledge but that neither of these skills is sufficient to build up trust with a patient. Patients using anti-depressants suffer from symptoms that concern them both clinically and socially, and they need a provider to be sympathetic. He said it is important to show genuine compassion and empathy because pharmacists who fake empathy can lose their customers to other providers. He said that if patients perceive they are being criticised or if the pharmacist forgets that the patient can recognise real compassion from fake compassion then this might impact on whether the patient takes their medication, and this can have a negative outcome. Also, this behaviour can have a negative effect on the professional life of the pharmacist.

7. Conducting an MUR: The Perception of the Patient : He said that patients are now becoming more familiar with receiving an invitation to come and have a Medicine Use Review and so they are more willing to engage with the pharmacist when asked. However, patient responses very much depend on how this review is conducted. Time can limit the opportunity to relate meaningfully with a patient, but small pieces of information relating to their medication and giving the patient a sense that you 'do care' can make a big difference to the individual.

8. The Patient's View towards the Pharmacist: He said that patients now view the pharmacist as more than just the person who 'dispenses their prescription' but that this perception is usually built over time. The longer you have served at an individual pharmacy, and the more accessible you are, then the greater the trust and respect that is shared between the patient and the pharmacist. However, He mentioned that some patients convey the attitude that no-one listens to their expectations or concerns, and, therefore, it is important to ensure that this kind of patient receives good knowledge about their treatment.

However, He mentioned that some patients convey the attitude that no-one listens to their expectations or concerns, and, therefore, it is important to ensure that this kind of patient receives good knowledge about their treatment.

9. The style of Communication Used

He said that every patient has their own communication style and that for every reaction from the patient there is an individual response from the pharmacist. This means that communication should be tailored for every patient.

For patients who feel stigma, then the pharmacist should try to focus on confidentiality at the beginning to build up comfort, but for a patient who is unsure of the role of the pharmacist, then the pharmacist should seek to reassure the patient that they are working side by side with doctors and nurses to treat the patient well, and this includes providing information about the correct use of medicines and how to cope with the treatment in their lives. Moreover, for patients who show concern and are worried, the pharmacist must use empathetic behaviour to encourage socialisation.

10. Conclusion

From the interview conducted with His, conclusions can be drawn as follows:

1. Patients can memorise some information from the provider, and they can gather and set insights for their next visit to the pharmacy relating to the impact of symptoms and vital information they need from the pharmacist.
2. Patients are looking for help from a person they can trust and they want to obtain information under conditions of privacy otherwise they are reluctant to enter into a consultation. Additionally, patients who take anti-depressants are sensitive and can differentiate between genuine empathy and faked empathy, and this is important for the pharmacist to know because it can affect outcomes.
3. Pharmacists who are skilful can offer consultations and advice using the right soft skills that are necessary to be empathetic, provide knowledge, and to deliver knowledge well. The pharmacist must be able to consider the most appropriate behaviour to acquire the satisfaction of the patient, and be able to deliver accurate information at the same time.

Appendix-6: Scenario Designed for an Actor

To perform the role of depressed patient Information for the simulated patient

1- Patient profile

- You are male, your name is Jim (you could say your name silently and if the pharmacist asks you again, try to be slightly nervous)
- You are 50 years old and British
- You live alone and you have no children

2- What you are suffering from:

- You have visited the pharmacy to collect your prescription for anti-depressants and the G.P. said you have depression.

Do not reveal information unless the pharmacist asks.

3- Symptoms:

- Feeling constantly tired, disturbed sleep
- Complaining of various aches and pains
- Want to stay in bed because it feels 'safe'

4- History:

- No allergies
- You have never been diagnosed with depression
- You are often tired, which may be related work 'you are not sure as to the cause'
- If the pharmacist asks you about sleep, say sometimes I feel it's difficult to get off to sleep and early morning waking
- You normally sleep around '9' hours but now you sleep nearly 5 hours and even when you sleep you do not feel refreshed

5- Treatment

- You have not had any treatment before

- Now: Ask the pharmacist what the prescribed treatment is?
 - S/he may answer, “The treatment is sertraline once a day. It belongs to a group called selective serotonin reuptake inhibitor.”
- Then ask the pharmacist about the medicine in detail
 - How does this medicine work?
 - Will I get any side-effects?
 - How bad will the side effects be?
 - How many times a day should I take the medicine?
 - When am I going to feel better?
 - How long should I take the medicine for?

6- Consultation

During consultation be aware:

- The pharmacist should give you enough information about the treatment such as, the duration of the treatment to feel the efficacy, some side effects.
- The pharmacist should advice you about food and life style
- The pharmacist should tell you how to approach him/her.

Appendix-7: Pharmacist Knowledge Questionnaire

The following statements are about your knowledge of depression and its management. When options are provided, please mark (X) the box to indicate your answer(s). For other questions, please write your answer in the space provided.

Please answer these questions briefly

1. State the names of three classes of anti-depressant medication.

2. What is the mechanism of action for SSRI medication to treat depression?

	Mark (X)
Serotonin-norepinephrine reuptake inhibitor	
Selective serotonin reuptake inhibitor	
Norepinephrine and dopamine reuptake inhibitor	

3. State three clinical indications for SSRI medication.

4. After starting SSRI medication, how soon will a typical patient experience the full therapeutic effect?

	Mark (X)
Within one month	
1-2 months	
3 or more months	

5. Are newer classes of anti-depressant medication (e.g. SSRIs) more or less effective than older classes (e.g. TCAs)?

	Mark (X)
--	----------

'Yes' newer are more effective	
'No' newer are less effective	
Classes have similar effectiveness	

6. Do newer classes of anti-depressants medication (e.g. SSRIs) have fewer side effects than older classes (e.g. TCAs)?

	Mark (X)
'Yes' newer have fewer side effects	
'No' newer have more side effects	
Classes have 'similar' side effect profiles	

7. Do newer classes of anti-depressants medication (e.g. SSRIs) have less harmful side effects than older classes (e.g. TCAs)?

	Mark (X)
'Yes' newer class have less harmful side effects	
'No' newer class have more harmful side effects	
Classes have 'similarly' harmful side effects	

8. Many side effects are common to both SSRIs and TCAs. Please mark (X) the appropriate column(s) to show which medication causes which side effect(s).

	<u>SSRIs</u>	<u>TCAs</u>
➤ a dry mouth		
➤ nasty indigestion		
➤ fast heartbeat		
➤ sexual function		
➤ constipation		
➤ weight gain		
➤ sleepiness		
➤ a slight tremor		

9. Do anti-depressant medications affect the patient's ability to drive or operate machinery?

	Mark (X)
--	----------

Yes	
No	
Don't know	

10. Can patients become addicted to anti-depressant medication?

	Mark (X)
Yes	
No	
Don't know	

11. Can SSRIs anti-depressants, promote suicidal feelings?

	Mark (X)
Yes	
No	
Don't know	

11a. If 'Yes', then when?

12. For a typical patient, how long is a course of anti-depressant medication?

	Mark (X)
3-6 months	
7-8 months	
More than 8 months	

13. What other forms of treatment are recommended by NICE for depression?

Thanks

Appendix-8: Pharmacist Attitude Questionnaire

The following themes and statements are about your attitude towards depression and its management. For each statement, please mark (X) the box that most closely matches your own level of agreement.

1= Strongly Disagree, 2 = Disagree, 3 = Uncertain, 4= Agree, 5= Strongly Agree

Themes and Statements	1 SD	2 D	3 UC	4 A	5 SA
Attitudes towards the nature and treatment of depression (treatment approach)					
1. Patients with depression need to pull themselves together to get over it.					
2. Depression mainly has psychological causes.					
3. Anti-depressants are addictive.					
4. Most patients with depression will get better without treatment.					
5. Children cannot suffer from a severe depression.					
6. Patients with depression need support and understanding from the people around them.					
7. Depression is not a real disease.					
8. Patients with depression generally do not understand information about their medication.					
Attitudes toward the course of depression (prognosis, evitable versus inevitable)					
9. Depression mainly has biochemical causes.					
10. Depression cannot be completely cured					

	1 SD	2 D	3 UC	4 A	5 SA
11. Patients with depression benefit most from treatment with anti-depressants rather than psychotherapy.					
12. Symptoms of depression are normal in older age.					
Attitude towards the pharmacists' role in care (role)					
13. Patients with depression receive all necessary information about this disease from their general practitioner or psychiatrist.					
14. Patients with depression do not want to talk about this with a pharmacist.					
15. Depression is a disease like any other.					
16. Patients with depression receive all necessary information about their medication from their general practitioner or psychiatrist.					
17. Patients with depression generally do not stick to advice given by providers about their medication.					
18. Patients with depression benefit most from psychotherapeutic treatment rather than anti-depressants.					
Attitude toward patients with depression (patients)					
19. ADs can change one's personality.					
20. Patients with depression put a strain on pharmacists.					
21. Patients with depression are unreliable.					

22. Most episodes of depression stem from negative life events.					
23. Weakness of character can cause symptoms of depression.					

Appendix-9: Patients’ Satisfaction Questionnaire before the Action Plan

PATIENT SATISFACTION SURVEY

Please tick the box that matches your personal details.

YOUR DETAILS

AGE	<input type="checkbox"/> 20-29 yrs.	<input type="checkbox"/> 30-39 yrs.	<input type="checkbox"/> 40-49 yrs.	<input type="checkbox"/> 50-59 yrs.	<input type="checkbox"/> 60-69 yrs.	<input type="checkbox"/> Above 70 yrs.
GENDER	<input type="checkbox"/> Male	<input type="checkbox"/> Female				
ETHNICITY	<input type="checkbox"/> White	<input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> Mixed	<input type="checkbox"/> Other	

The following statements are about your satisfaction with your pharmacist’s service. For each statement, please tick the box that most closely matches your own level of agreement.

YOUR OPINIONS	Not at all	A little bit	Somewhat	Quite a bit	Very much
1. My pharmacist offers to talk to me in private.					
2. My pharmacist advises me on the proper use of my medicines.					
3. My pharmacist advises me on the adverse (side) effects of my medicines.					
4. I have confidence in my pharmacist’s knowledge about depression and its treatment.					
5. I have confidence in my pharmacist.					
6. My pharmacist is available to answer my questions.					
7. My pharmacist is willing to talk to me about my symptoms of depression and progress with treatment.					
8. My pharmacist helps with the arrangements necessary to obtain my medicines.					
9. My pharmacist is aware of my treatment-related needs.					
10. My pharmacist responds to my treatment-related needs.					
11. I would recommend my pharmacist to other people with depression					

PLEASE ADD ANY COMMENTS OR CONCERNS

When complete place in the envelope and return by post.

Appendix-10: Simulation Venue: A Mock Pharmacy



Appendix-11: Skills Checklists during the Simulations



Check lists for assessing pharmacist's skills 'simulation'

Rating Scales for Evaluation

Three different rating scales are included in the framework:

A Individual rating scales

The assessments of individual activities and behaviours require a 'yes/ no' assessment (marked as tick/cross). Some activities may not be relevant in every type of consultation and can therefore be marked as 'not applicable (N/A)'. Please refer to the example below.

e.g. Did I undertake the following activities when consulting with the patient?

Introduce self to patient	✓	If your answer is yes, please place a tick in the space provided
Confirms patient identity	NA	If the described activity is not applicable to this consultation, please state N/A
Discusses purpose and structure of the consultation	X	If your answer is no, place a cross in the space

B Ratings for each framework section

Section rating scales are included at the end the individual framework sections A to E. These ratings are intended to assess whether the overall aim of each individual framework section was achieved. This is measured on a 5 point scale with the middle and extreme points anchored by explicit descriptors; and ranges from 'fully', 'partially', and 'not achieved'.

C Final overall rating scale

This allows for a final reflective assessment of the entire consultation and the assessment is on a 5 point scale ranging from 'poor', 'borderline', 'satisfactory', 'good' and 'very good'

Space for comments

In addition to above rating scales a comment box is provided that gives the evaluator the option to provide the learner with more specific feedback about his/her strengths and weaknesses and/or to clarify ratings given.

Medication related consultation frame work (MRCF)

Name:

Date:

1 Introduction

Introduces self to patient

Invites patient to discuss medication or health related issues

Discussion purpose and structure of the consultation

Negotiates shared agenda

The practitioner was **NOT** able to build a therapeutic relationship with the patient

0 1 2 3 4

The practitioner was **FULLY** able to build a therapeutic relationship with the patient

Comments:

2 Data collection and problem identification

Medication history, Social history

How often patient misses dose(s) of treatment

Patient's understanding of the rational for prescribed treatment

Reason for missed dose(s) (unintentional or intentional)

Patient's (lay) understanding of his/her illness

Identifies and priorities patient's pharmaceutical problems (summarising)

The practitioner was **NOT** able to identify the patient's pharmaceutical needs

0 1 2 3 4

The practitioner was **FULLY** able to build a therapeutic relationship with the patient

Comments:

3 Actions and solutions

Relates information to patient's illness and treatment beliefs (risk-benefit discussion)

☐

Check patient's ability to follow plan (are any problem anticipated?)

☐

Involves patient in designing a management plan

☐

Check patient's understanding

☐

Gives advice on how and when to take medication, length of treatment and negotiates follow up

☐

Refers appropriately to other health care professional(s)

☐

The practitioner was **NOT** able to establish an acceptable management plan with the patient

0 1 2 3 4

The practitioner was **FULLY** able to establish an acceptable management plan with the patient

Comments:

4 Closing

Explains what to do if patient has difficulties to follow plan and whom to contact

☐

Provides further appointment or contact point

☐

Offers opportunity to ask further questions

☐

The practitioner was **NOT** able to negotiate 'safety netting' strategies with the patient

0 1 2 3 4

The practitioner was **FULLY** able to negotiate 'safety netting' strategies with the patient

Comments:

5 Consultation Behaviour

Did the practitioner demonstrate the following consultation behaviours?

Listens actively & allows patient to complete statements	<input type="checkbox"/>
Demonstrates empathy and supports patient	<input type="checkbox"/>
Uses open & closed questions appropriately	<input type="checkbox"/>
Adopts a structured & logical approach to the consultation	<input type="checkbox"/>
Accept patient (i.e. respect patient, is not judgmental or patronising)	<input type="checkbox"/>
Manages time effectively (works well within the time available)	<input type="checkbox"/>
The practitioner was NOT able to demonstrate any of these consultation behaviours	<div>0 1 2 3 4</div>
The practitioner was FULLY able to demonstrate these consultation behaviours	
Comments:	

Total number of marks for each section...../20

Overall Impression

Over all my ability to consult was...	Not competent - poor	Not competent - borderline	Competent - satisfactory	Competent - Good	Competent - Very good
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Comments:					

Appendix-12: Gibbs' Model of Reflection 'post-simulation'

The reason/s for participating

Description	<p>This is the context of the event e.g.</p> <ul style="list-style-type: none">➤ Who was there?➤ Why were you there?➤ What was happening?
Feelings thoughts	<p>This is self-awareness e.g.</p> <ul style="list-style-type: none">➤ How did you feel at the time?➤ What did you think at the time?➤ What did you think about the incident afterwards?
Evaluation	<p>Consider your judgments e.g. about what has happened. Consider</p> <ul style="list-style-type: none">➤ What was good and not so good about your experience or did not go so well?
Analysis	<ul style="list-style-type: none">➤ What went well?➤ What did you do well?➤ What went wrong or did not turn out?➤ How it should have done?
Conclusion	<ul style="list-style-type: none">➤ What you could have done differently?
Action plan	<ul style="list-style-type: none">➤ Would you act differently or would you be likely to do the same?

Appendix-13: Action Plan

Structure for CPD recording for entries starting at reflection

Name of entry:

Date entry started:

Reflection on practice (Identifying what you want to learn and why).

What do you want to learn?

What you need to learn may be new knowledge, skill(s), or a new attitude – anything that you think will make you better able to do your job as a pharmacy professional or prepare you for a new service or role. You should be as specific as possible.

How is this learning relevant to the safe and effective practice of pharmacy and to your own scope of practice? Explain how you chose what to learn and why. this bit of learning is relevant to your practice as a pharmacy professional.

Tick one or more methods that you used to identify what you needed to learn.

Critical incidents

Audit

Appraisal

Feedback from users of service/products

Peer review/talking to colleagues

Reading

Personal interest

Other

Planning your learning activities (Identifying priorities)

When will you need to have achieved this learning? (dd/mm/yy)

Putting an estimated date may help you to set priorities for your learning. Be as specific as possible, but do not worry if the date is just an approximation.

Why is this learning important to you and your practice?

Write a brief description of how this learning will affect you, your service users, your colleagues and your organisation. If you do not think that your learning will have a significant impact on anyone, you might want to consider why you are undertaking and recording this learning.

You can use the scale below to rate the importance of this learning, but you also need to fill in the box above too.

	Low	Moderate	High	Very high
None				
Importance to you				
Importance to the users of your services or products				
Importance to colleagues				
Importance to organisation				

What might you need to do in order to achieve this learning?

It is important for you to consider a range of options for achieving your learning. Aim to list a few different options e.g. attend workshops, study open learning packs, talk to colleagues. Outline what you think are the advantages and disadvantages of each option. You may not choose to complete all the options that you have listed, but it is important to show that you have considered them.

Option	Description of different options	Advantages	Disadvantages	Select ✓ or x

Action:

When did you complete the activities outlined in your plan?

Record the date you completed the activities that you chose from your plan. If you need to keep a continuing education record for other organisations then you may find it useful to jot down how long each activity took, but this is not a requirement. The number in the option column should correspond to the options you selected in the question above (P3).

Option	Description of what you did	Date completed

What have you learnt?

Describe what specific skill, knowledge, attitudes and/or behaviours you have gained from your learning. This may be different to what you originally set out to learn.

--

Evaluation (Reflecting on learning)

Have you been successful, what are the benefits?

To what extent did you learn what you set out to learn at the start of this CPD cycle?

You may find it useful to revisit the 'Reflection' page and decide on what you originally wanted to learn before you decide to what extent you have achieved that learning.

- Fully
- Partly
- Not at all

If you ticked fully or partly, give an example of how you have applied or how you intend to apply what you have learnt to your practice.

Putting learning into practice is a good way to prove that you have actually learnt what you set out to. It may be a while before you apply what you have learnt. It is fine to leave this box blank and come back to it when you have had a chance to put your learning into practice.

If you ticked 'fully' or 'partly', what have been or what will be the benefits of this learning to your practice?

You might find it useful to revisit your 'Planning' page and consider how you, your service users, your colleagues and your organisation have actually benefited or will benefit from your learning. Do include any feedback about your practice, formal or informal, that you have had from other people.

If you ticked 'partly' or 'not at all', describe what it is you still have to learn.

You may find it useful to revisit the 'Reflection' page and check on what it is you originally wanted to learn before you describe what it is you still need to learn.

If you ticked 'partly' or 'not at all', explain why you think you did not achieve your learning.

You may find it useful to revisit the 'Reflection' and 'Planning' pages to work out why you did not achieve everything you set out to learn. It is all right for you not to have achieved all of your learning, but it is important that you explain why.

If you ticked 'partly' or 'not at all', what do you intend to do next?

- Nothing, I've learnt enough for what I need
- Review to see if I can complete what I want to learn within this CPD cycle
- Start a new CPD cycle and complete what I want to learn.

Appendix-14: Patients’ Satisfaction Questionnaire after Action Plan

PATIENT SATISFACTION QUESTIONNAIRE

Please tick the box that matches your personal details.

YOUR DETAILS

AGE	<input type="checkbox"/> 20-29 yrs.	<input type="checkbox"/> 30-39 yrs.	<input type="checkbox"/> 40-49 yrs.	<input type="checkbox"/> 50-59 yrs.	<input type="checkbox"/> 60-69 yrs.	<input type="checkbox"/> Above 70 yrs.
GENDER	<input type="checkbox"/> Male	<input type="checkbox"/> Female				
ETHNICITY	<input type="checkbox"/> White	<input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> Mixed	<input type="checkbox"/> Other	

The following statements are about your satisfaction with your pharmacist's service. For each statement, please tick the box that most closely matches your own level of agreement.

YOUR OPINIONS	Not at all	A little bit	Somewhat	Quite a bit	Very much
1. My pharmacist offers to talk to me in private.					
2. My pharmacist advises me on the proper use of my medicines.					
3. My pharmacist advises me on the adverse (side) effects of my medicines.					
4. I have confidence in my pharmacist's knowledge about depression and its treatment.					
5. I have confidence in my pharmacist.					
6. My pharmacist is available to answer my questions.					
7. My pharmacist is willing to talk to me about my symptoms of depression and progress with treatment.					
8. My pharmacist helps with the arrangements necessary to obtain my medicines.					
9. My pharmacist is aware of my treatment-related needs.					
10. My pharmacist responds to my treatment-related needs.					
11. I would recommend my pharmacist to other people with depression					

PLEASE ADD ANY COMMENTS OR CONCERNS

When complete place in the envelope and return by post.

Appendix-15: The Demographics of the Participants

Participants	Age (Yrs.)	Gender	Total qualified experience (Yrs.)	Experience in community pharmacy (Yrs.)	Experience in other health settings (Yrs.)	Academic experience (Yrs.)
1	28	Male	5	5	3 (hospital)	2
2	35	Male	12	12		7
3	37	Female	15	15		5
4	23	Female	-	-		
5	24	Male	-	-		
6	24	Male	-	-		
7	32	Male	8	8		
8	33	Male	7	7		
9	28	Male	4	4		
10	33	Male	11	11		
11	42	Male	18	18		
12	28	Male	2	2		
13	24	Male	0.5	0.5		
14	24	Male	3	1		
15	28	Male	3	3		
16	35	Male	8	8		
17	24	Male	0.5	0.5		
18	28	Female	3	3		
19	28	Male	3	3		
20	29	Male	3	3		
21	26	Female	2	2		
22	33	Female	10	10		

Appendix-16(A): Approval of Ethics Reviews for Community Pharmacists Participation

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THIS FORM SHOULD BE TYPEWRITTEN



Ethics Application Ref No: E.281

ETHICS REVIEWER'S COMMENTS FORM

This form is for use when ethically reviewing a research ethics application form. Please note: your comments will guide the Panel in their decision and may be forwarded to the applicant for information.

1. Name of Ethics Reviewer:	Reviewer 1
2. Research Project Title:	Improving Communication between Pharmacists and People with Depression
3. Principal Investigator (or Supervisor):	Dr Jon Silcock
4. Academic Department / School:	Pharmacy/SLS

5. Do you have any potential conflict of interest with regard to this project application. NO

If you answered YES, then please clarify:

6. I recommend that, in my judgment, the application should be:

Approved [recommended comments for information only]:	Approved once the Minor amendments required have been satisfactorily addressed [on which Chair can act]	Major amendments required - recommend to be seen by Panel	NOT be approved for the reason(s) given below:
√			

7. Reviewers comments:

[NOTE:

Required: minor or more major amendments required before approval can be given.

Recommended: recommendations will be sent to applicant for information only.]

Study design / methodology

Required:

Recommended:

- Perhaps remove the final question on Table 2 questionnaire (experience with depression in the personal environment) for the pilot only. I can see its value for the final questionnaire, but I think this question could cause some anxiety amongst some of our final year students who might be willing to participate. Or - make it clear students do not have to answer this question (eg, this question is optional).

Appendix-16(A): Approval of Ethics Reviews for Community Pharmacists Participation

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THIS FORM SHOULD BE TYPEWRITTEN


Required:
Recommended:
Participant consent and information sheet
No recommendations
Required:
Recommended:
Risks and ethical problems
No recommendations
Required:
Recommended:
Compensations/Indemnity
No recommendations
Required:
Recommended:
Confidentiality
Required:
Recommended: It may be appropriate to make it clear in the participant information sheet, that video recordings will not be used for any other purpose aside from this study.
General comments
<p>There are a number of statements and uses of terminology on the project proposal that do not conform with current practice/or are unfounded. Specifically:</p> <ul style="list-style-type: none"> the use of the term 'mental diseases' should be avoided. This should be replaced with 'mental disorder' or even, 'mental health problems' e.g. ICD-10 Major depressive disorder. 'People put a social distance between themselves and those perceived to have mental health problems.' page1. Please reference this, and qualify with 'It has been found that some . . . ' or similar. 'By definition, patients with mental health problems will lack some level of capacity for informed decision making' p2. This comment is extremely controversial. You have not justified this point of view. It is not true by definition. It concerns me on an ethical level because it suggests that you do not have a good grasp of the nature and current understanding of mental health issues.

DATE: 30/03/13

Appendix-16(B): Approval of Ethics Reviews for Community Pharmacists Participation

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THIS FORM SHOULD BE TYPEWRITTEN

 **UNIVERSITY OF BRADFORD**
MAKING KNOWLEDGE WORK

Ethics Application Ref No: E.281

ETHICS REVIEWER'S COMMENTS FORM

This form is for use when ethically reviewing a research ethics application form. Please note: your comments will guide the Panel in their decision and **may** be forwarded to the applicant for information.

1. Name of Ethics Reviewer:	Reviewer 2
2. Research Project Title:	Improving Communication between Pharmacists and People with Depression
3. Principal Investigator (or Supervisor):	Dr Jon Silcock
4. Academic Department / School:	Pharmacy/SLS

5. Do you have any potential conflict of interest with regard to this project application. NO
If you answered YES, then please clarify:

6. I recommend that, in my judgment, the application should be:

Approved [recommended comments for information only]:	Approved once the Minor amendments required have been satisfactorily addressed [on which Chair can act]	Major amendments required - recommend to be seen by Panel	NOT be approved for the reason(s) given below:
	yes		

7. Reviewers comments:

[NOTE:
Required: minor or more major amendments required before approval can be given.
Recommended: recommendations will be sent to applicant for information only.]

Study design / methodology

Required: More detailed of methodology including choice of sample size, methods of data analysis. Without these details it is not possible to evaluate this research proposal. If the methodology isn't sound, then it isn't ethical to gather the data on students required.

Recommended:

Recruitment of participants

No recommendations

University of Bradford Research Ethics Reviewer's Comments Form V2 (i) page 1

Appendix-16(B): Approval of Ethics Reviews for Community Pharmacists Participation

PRIVATE AND CONFIDENTIAL

THIS FORM SHOULD BE TYPEWRITTEN

Required:
Recommended:
Participant consent and information sheet
No recommendations
Required:
Recommended:
Risks and ethical problems
No recommendations
Required:
Recommended:
Compensations/Indemnity
No recommendations
Required:
Recommended:
Confidentiality
Required:
Recommended: It may be appropriate to make it clear in the participant information sheet, that video recordings will not be used for any other purpose aside from this study.
General comments
<p>There are a number of statements and uses of terminology on the project proposal that do not conform with current practice/or are unfounded. Specifically:</p> <ul style="list-style-type: none"> the use of the term 'mental diseases' should be avoided. This should be replaced with 'mental disorder' or even, 'mental health problems' e.g. ICD-10 Major depressive disorder. 'People put a social distance between themselves and those perceived to have mental health problems.' page1. Please reference this, and qualify with 'It has been found that some . . . ' or similar. 'By definition, patients with mental health problems will lack some level of capacity for informed decision making' p2. This comment is extremely controversial. You have not justified this point of view. It is not true by definition. It concerns me on an ethical level because it suggests that you do not have a good grasp of the nature and current understanding of mental health issues.

DATE: 30/03/13

Appendix-17: Application form for Research Ethics Approval



APPLICANT'S ETHICS CHECKLIST

This checklist is designed to help you to decide whether or not ethics approval is required and, if required, to decide on the appropriate ethics review procedure – please read guidance on page 5 before you complete the form

Who should use the checklist?

A checklist should be completed for all empirical research projects involving people, by the Principal Investigator [PI] or the Principal Supervisor [PS] in the case of a supervised student research project.

Guidance on the 2 different ethics review procedures that together make up the University's Ethics Review System (i.e. 'University' and 'NHS') is available on the [University Ethics website](#)

If the project involves human tissue/biological fluids you should contact the University human tissue bank for advice in the first instance. Contact Ethical Tissue on 01274 235897 or visit www.ethicaltissue.org

Project Title: Improving communication between pharmacists and people with depression
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Name of Principal Supervisor: Dr. Jonathan Silcock
.....

Contact Details – email address j.silcock@bradford.ac.uk

Department/School: School of Pharmacy, Pharmacy Practice Research
.....

Name of Student/Principal Investigator: Adel Alshammari(PhD Student)

Contact Details – email address aalshamm@student.bradford.ac.uk
.....

SUMMARY OF PROJECT (max 150 words)

Depression is one of the most common mental illnesses affected people of all ages and social class. The incidence of depression may be influenced by gender, poverty, bereavement, and genetics among other factors. The symptoms of depression may include loss of interest in life and loss of appetite. However, detecting depression may not be easy and clinicians may fail to make a proper diagnosis. After diagnosis lack of understanding and the symptoms of depression may be barriers to patient adherence. If patients do not take medication as prescribed, then this may prolong the illness and increase healthcare workload. Pharmacists are in a good position to reinforce key messages about adherence and monitor some aspects of patient recovery. Experience suggests pharmacists do not proactively adopt this role and do not always communicate effectively with depressed patients. This research exhibit a simulation exercise to assess the pharmacists' communication skills and confidence when dealing with people who have depression. Community pharmacists will be recruited from NHS.

Q1	<p>Is the proposed project an <u>empirical research</u> project involving people?</p> <ul style="list-style-type: none"> • will the project include primary data collection from human subjects, their data or their tissue? • Will it constitute an ‘investigation undertaken in order to gain knowledge and understanding’? (this includes work of educational value designed to improve understanding of the research process) <p>A more detailed definition of Research, Audit and Service Evaluation is available on the University Ethics website.</p> <p>If you answer ‘Yes’ to Q1 ethical approval may be required, move to Q2. If you answer ‘No’ to Q1 then a research ethics review is <u>not</u> required.</p> <p>Note: there may be occasions where a project is not defined as research but still raises ethical issues – please submit for review in these cases.</p>	YES
Q2	<p>Will the research project involve the <u>NHS</u>?</p> <p>See guidelines on the University Ethics website If you answer ‘No’ to Q2 move on to Q3 If you answer ‘Yes’ to Q2 ethical approval will be required by NHS Research Ethics Committee (REC) Contact Ethical Tissue on 01274 235897 or visit www.ethicaltissue.org</p>	YES
Q3	<p>Will the research project involve any of the following in the UK:</p> <ul style="list-style-type: none"> Testing a medicinal product Investigating a medical device Taking samples of human biological material (e.g. blood, tissue) Prisoners or others in custodial care (e.g. young offenders) as participants Adults with mental incapacity as participants Other vulnerable groups (e.g. vulnerable children) as participants <p>If you answer ‘Yes’ to Q3 ethical approval will <u>usually</u> be required by Ethical Tissue or NHS Research Ethics Committee (REC) or where the project includes participants which need approval under the Mental Capacity Act approval will be required by the Social Care REC.</p> <p>See information specific to research in Social Care on the University Ethics website</p> <p>If you answer ‘No’ to Q3 move on to Q4</p>	NO
Q4	<p>Will the research project involve human participants and/or human data (<u>but not accessed through the NHS</u>)?</p> <p>If you answer ‘Yes’ to Q4 University ethical approval is required unless data/participation is uncontentious (see guidance overleaf) If you answer ‘No’ to Q4 move on to Q5</p> <p>Please give brief explanation below of type of data/participation in cases which you consider to be uncontentious (see guidance on page 5):</p>	YES

Q5	<p>Will the research project involve <u>human tissue (but not requiring NHS approval – see Q3)</u>?</p> <p>If you answer 'Yes' to Q5 University ethical approval is required</p> <p>If you require advice on human biological material please contact Human Tissue Act (HTA) Designated Individual: Professor Diana Anderson on ext 3569 or email: d.anderson1@bradford.ac.uk</p> <p>Contact Ethical Tissue on 01274 235897 or visit www.ethicaltissue.org</p>	NO
Q5a	<p>If you answered 'Yes' to Q5, is the human material over 100 years old and archaeological?</p> <p>If 'YES' please refer to the Biological Anthropology Research Centre (BARC) guidelines at http://www.barc.brad.ac.uk/BARC_human_remains_policy.pdf</p>	NO
<p>If you answer 'No' to Q5 and have answered 'No' to Q2, Q3 and Q4 ethical approval is <u>not</u> required.</p>		

PLEASE COMPLETE and SIGN ONE of the boxes below:

1. I have discussed this project with my student and
2. confirm that there are **no ethical issues** requiring further consideration.

(Any subsequent changes to the nature of the project will require a review of the ethical considerations)

Name (Principal Investigator/Principal Supervisor):

Signature:

Date:

Name (Student):

Signature:

Date:

I confirm that there are **ethical issues** requiring further consideration and will refer the proposal either to [Ethical Tissue](#) or fill in and submit a full ethics application to be considered by the appropriate Research Ethics Panel.

Name Principal Supervisor

Dr Jonathan Silcock

Name Principal Investigator

Adel Alshammari (PhD Student)

Signature:

Adel

Date: 5/10/2013

Checked by Chair of Research Ethics Panel

Annex 1

Ethical Scrutiny by a University Research Ethics Panel is not required if:

- The project is NOT a research project.
- The research project will only involve **unlinked or aggregated human data which was collected and which was, at the time, subject to relevant research ethics panel approval.**

However, where this is the case the researcher should at least confirm this in an email to the Research Support Unit's Ethics Administrator so that the Ethics Administrator has a record and can inform the Chair of the appropriate Research Ethics Panel that the researcher plans to go ahead without ethics approval. The email should confirm that the research project does not require ethics approval because it only involves unlinked or aggregated data, which when originally obtained from people was obtained in accordance with the protocol as approved at the time by an appropriate research ethics panel. The email should also briefly explain how the researcher now plans to use the unlinked or aggregated data.

- **The research is Public Domain Data:**

The Economic and Social Research Council's (ESRC) Research Ethics Framework states that ethics approval may not be required for data sets that exist in the public domain (e.g. datasets that are available from the Office for National Statistics or from the ESRC's Data Archive) so long as the appropriate permissions from individuals have already been obtained (i.e. informed consent) and where it is not possible to identify the individuals from the information provided. It must be remembered that public domain data is still covered by the laws of copyright.

- **The research involves Simple Uncontentious Questionnaires:**

If a research project's only involvement with human subjects is a simple brief questionnaire with uncontroversial content it may not require ethical approval. It is the Principal Investigator or Principal Supervisor's responsibility to decide whether a project comes under this category and must indicate this on the form and attach the document for information.

Guidance on supervisor and principal investigator sign off of uncontentious research

Audit and service evaluation are usually uncontentious, and guidance on how to differentiate between research, audit and service evaluation is given at: [University Ethics website](#).

Even where a project is clearly research, as a supervisor or principal investigator, you can sign off simple, ethically uncontentious projects as not needing further ethical scrutiny. To do this, you should consider the level of risk to participants and researchers, the level of effort required by participants, the level of intrusion into participants' lives and the level of sensitivity of both the general subject matter and the information requested of participants. Basically, the lower these levels, the more likely the research is to be uncontentious and the more confident you should feel about signing off.

The following examples may help.

These studies can almost always be signed off by the supervisor or principal investigator:

- Brief questionnaires asking opinions about matters which are clearly not sensitive (attitudes to a product, beliefs about the usefulness of a course).
- Brief interviews about such topic.
- Observational studies about everyday behaviour in public places which involve no risk to subjects or the researcher.

But the following studies almost always need further scrutiny by a University Ethics Panel:

- Long questionnaires (these require considerable potential inconvenience to subjects).
- Long interviews
- Any questionnaires which ask subjects about intimate behaviours or issue likely to cause distress or would in other ways normally be regarded as contentious or sensitive (e.g. illegal activities, attitudes to abortion, capital punishment, immigration, euthanasia).
- Any interviews which examine these matters.
- Observational studies which involve intimate behaviours, behaviours which are not normally public or which might normally be considered contentious or sensitive (Activities of ethics committees, appointment committees, etc; professional consultations).

Naturally, this list is for illustration only, and should not be considered in any way exhaustive, permissive or prescriptive. For example, there are many categories of research not mentioned here which would definitely require ethics approval (e.g. treatment research). Rather the list demonstrates the issue of proportionality. Thus, even though the method may be the same for activities requiring and not requiring further scrutiny, the content in some way distinguishes between the two categories.

At the same time, there is obviously some middle ground. Are ethics committees not public? Is what is discussed so sensitive that the proposal needs further scrutiny? What about asking people about their views on the actions of senior members of staff in their organisation? Probably, it is in these middle ground areas that further advice should be sought from a Panel Chair about whether the project can be signed off by the supervisor or principal investigator alone. Given that, in so doing, the supervisor or PI is attesting to the ethical probity of the study, it is usually best to err on the side of caution where there is uncertainty. Panel chairs are very happy to advise.

(**Dr Martin Brinkworth**, Chair, Biomedical, Natural and Physical Sciences Research Ethics Panel, m.h.brinkworth@bradford.ac.uk, ext. 3584

Andy Scally, Chair, Humanities, Social and Health Sciences Research Ethics Panel,

Please return Checklist to:

Lynda Nuttall, Ethics Administrator, Research Support Unit,
Research and Knowledge Transfer Support, ext. 3170, [l.d.nuttall@bradford.ac.uk]

Appendix-18: Participant's' Agreement to Take Part in Research

Study title:

Name of the researcher:

Please tick each box to agree with the statements

1. I have read the information sheet for this study.	
2. I have had the chance to ask questions about the study.	
3. I understand the reasons for this study and how I will be involved.	
4. I understand that I may not gain any direct personal benefit from the study and I accept this.	
5. I understand that all information collected will be treated confidentially.	
6. My personal details will be removed from any publications or presentations.	
7. I confirm that I am taking part in this study of my own free will. I am free to withdraw from the study at any time and for any reason.	
8. If I withdraw from the study, then I may ask for my video and any other personal information to be destroyed.	
9. I agree to take part in this study.	

Participant Name

Signature

Date

Researcher Name

Signature

Date

You (the participant) will keep one copy of this consent form, and the researcher will keep another copy

Appendix-19: Participants' Information Sheet

Improving community pharmacy consultations for people with depression

Dear Pharmacist

My name is Adel Alshammari. I am a PhD student in pharmacy practice research. I invite you to take part in my research project. Please read this information carefully before you decide what to do. Please contact me (or my supervisor) if you have any questions.

Why have I been invited to take part?

You have been invited to take part because you are a practicing community pharmacist. We have piloted the study procedures with students and teacher practitioners at the University of Bradford.

What is purpose of the project?

The purpose of this research is to assess the communication skills of community pharmacists when talking to people with depression. We don't think we can assess this directly in your practice, so we have designed a simulation exercise (role play). Assessing the simulation performance will provide us with information about the professional standard of care without the need to inconvenience or recruit patients

Do I have to participate?

- You are free to decide whether or not to participate.
- If you agree, I will give you this information letter to keep, and you must sign a consent form to say that you have read the information and agree to the conditions.
- If you do not agree, you are still free to change your mind at any time and without giving a reason.
- If you do withdraw at any time, then you may also ask for any data already collected to be destroyed, and we will do this for you.

Who is conducting the investigation?

The investigation will be carried out by me (Adel Alshammari), under the supervision of Dr Jon Silcock, Dr Josie Fraser and Prof Alison Blenkinsopp.

Please contact me or Dr Silcock if you have any questions

(aalshamm@student.bradford.ac.uk; J.Silcock@bradford.ac.uk). This study has been reviewed by a University of Bradford ethics panel.

What will I have to do if I take part?

- We will give you some satisfaction questionnaires to distribute to your patients before and after an assessment of your consultation skills.
- You will complete two questionnaires, one about knowledge of depression and a second about attitudes towards people with depression.
- You will come to the University of Bradford to consult with a simulated patient in our mock community pharmacy.
- The simulated patient will act out a realistic scenario, in which you dispense a prescription and give any necessary advice.
- The patient is an experienced actor, and not a member of academic staff.
- The consultation will be video recorded and you will be able to watch it back.
- There will then be a short interview with the researcher and the actor.
- The interview will be audio and/or video recorded, so that a transcript can be made.
- The whole process should take about 1 hour.
- You will get feedback and may be asked if you want to repeat the simulation at a later date (this will be optional).
- We will analyse responses from your patient satisfaction questionnaires and provide you with a summary.

What are the probable benefits?

- You will be helping us to develop this model of practice assessment.
- After simulation you might become confident helping people with depression.
- You may benefit from the consultation skills practice.
- We will give you a summary of your performance and the overall results, which may help to guide your professional development and complete a CPD cycle.

Are there any risks?

- You may find the role play experience a little stressful, but we are not really judging your performance.

- We will make a recording, but this will only be used for research purposes. It will not be used for teaching or broadcast in any way.
- You may stop at any point for break or if you want to withdraw from the study.
-

Will my response be kept confidential?

All responses will be strictly confidential. Your personal data and video will be destroyed but not until the study has been completed and any papers published, which may be in about 3 years' time.

Can I withdraw from the investigation?

You may withdraw at any time and ask for your data or recordings to be destroyed. Please just ask any member of the research team.

Thank you for reading this information. If you agree to participate, then you will be provided with a copy of this information sheet and a signed consent form to keep.

Appendix-20: Definitions of Themes and Categories

Terms	Definition
1. The Attitude of the Participants	An individual's favourable or unfavourable feelings about performing the behaviour (Fox, 2005).
A. Nature of Depression	The severity of the disease and the extent to which it can affect the patient's mood, body, and ability to function in the community and receive treatment.
A1. Causes of Depression	Beliefs held by the participants about the causes of depression.
A2. Coping with Depression	The perspective of the participants of behaviour of patients when taking their medications and communicating with other people in the society.
B. Managing People with Depression	The participants' perception of anti-depressants in comparison to drugs used for physical diseases.
B1. Positive Beliefs about Managing Depression	The ability of the participants to manage mental illness and it is beliefs using the same approach taken for physical diseases.
B2. Negative Beliefs about Managing Depression.	The inability to manage people with depression in comparison to managing people with physical diseases.

C. Stigma Associated with Depression	The feeling of being judged and stereotyped in the community and by health care providers.
C1. Stigma Attached to Depression from the Perspective of Professionals	Feelings experienced by the patient triggered by the presence of other people in the pharmacy, for example participants.
C2. Stigma Attached to Depression from the Perspective of Non-pharmacy Staff.	Feelings experienced by the patient triggered by the presence of other people working in the pharmacy, for example serving staff.
D. Time Allocated for Providing Services to Patients	Management of time in the pharmacy.
D1. Participants' Perception of GPs' Time	Participants' view of GP time.
D2. Experience of Time Constraints When Trying to Help Patients	The limitations on time which hinder the participants' ability to provide proper standards of service.
D3. Dedicated Time to Help Patients	The keenness to provide a service and to prioritise patients by giving them enough time to explain their problem fully.
E. Privacy of Patients	Effect of privacy on participants-patient interaction.
E1. Offering Privacy	Willingness of the participants to offer privacy to patients.

E2. Offering Less Privacy	Less willing to offer privacy to patients consultation.
E3. Environment of Privacy Compared to other Health Care Setting	The opinion of the participants about the privacy of pharmacy compared to other clinical setting.
2. Participants' Engagement with Patients	Participants encouraging patients to participate in the discussion.
F. Training Needed to Engage with Patients	A lack of confidence demonstrated by participants to involve themselves with patient queries.
F1. Role Perception	Self-insight of the participant's role in health care promotion.
G. Lack of Patient Knowledge about the Role of the Pharmacist	Patients' awareness or unawareness of the pharmacist's role.
H. Lack of Liaison with Other Health Care Professionals	The participant's lack the connection with other health care professionals for follow up for patients.
H1. Hierarchy of Health Care Professionals	Participants who are less engaged in decision making about a patient's treatment in comparison with other health care professionals.

I. Organisational Barriers	The lack of a facility to systematically link up with other health care professionals.
3. Tailoring the Consultation	The competency of the participants when communicating information which match to patients' needs.
J. Developing Skills in the Practice	Being unconscious of skills developed through long time practice when providing services.
K. Initiating the Session	The initial rapport of participants- patients.
K1. Negotiating the Patient's Agenda	Pharmacists exploring patients' concerns, expectations and awareness of their treatment.
L. Giving Information to Patients	The ability of the participant to provide medical and non-medical information, listening to patients and checking their understanding.
L1. Information Sharing about Anti-Depressants.	Enhancing patients' awareness of the use, efficacy and safety of anti-depressants.
L2. Giving Patients' Opportunity to Talk.	Listening to patient concerns and encouraging them to share information with the participants about their treatments.

L3. Picking up the Patient's Cue	Understanding the patient's vocal and non-vocal behaviour.
L4. Checking Patients' Understanding	The ability of the participants to encourage patient to tell back.
L5. Less Information Sharing about Social Treatment.	Unwilling to support patient with information about social information.
4. Staging Advice to Patients	Giving the correct amount of information to patients to match the stage of treatment.
M. Quality of Information at First Time Consultation	The quality and quantity of information tailored to the patients' satisfaction.
N. Relationship of Participants with Patients	The direction of the participant's relationship with patients when meeting them - one way/two ways.
N1.Paternalistic Attitude	A participant who take the responsibility on behalf of patient about their treatment.

N2. Passive Behaviour of the Participants	When the participant is unwilling to take an action to help or support patients.
N3. Building up Relationships with Patients	The importance of building relationships and offering advice to people with depression.
N4. Relationship Management for Regular Patients	Regular visiting of patients to enhance the relationship with the participant to enabled them to provide health care to patients comfortably.
O. Follow Up Service	The willingness of the participants to promote health care.
O1. Accessibility of the pharmacist to the patient	Offering accessibility to enhance patient awareness of the service provide in the pharmacies and the role building relationship.
O2. Advanced Services	The service recommend by health care systems to encourage enhancing patients to adhere to taking their medications on schedule.